

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2001 | |
|---|--------------------|--|--------------------------------|--|---|
| 5-350 71 2001 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Charles D Stem</i> | | 2. DATE AND HOUR OF DEATH <i>Feb 24, 1971 2:45 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED HOSPITAL OR INSTITUTION <i>44 Union Memorial Hosp.</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Carroll</i> 5627 C. CITY OR TOWN <i>Westminster</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>64 1/2 Winchester Ave.</i> | | | |
| | | | | | |
| 5. SEX <i>M</i> | 6. RACE <i>Cau</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5/8/29</i> | | 9. AGE (In years lost birthday) <i>41</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine Operator</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Shoe Mfg.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Walter L. Stem Sr.</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Margaret Chilote</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | |
| 16. SOCIAL SECURITY NO. <i>217-26-1190</i> | | 17. INFORMANT <i>Leonard L. Stem</i> ADDRESS <i>814 W. 37th St.</i> | | | |
| 18. <i>431.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH <i>Cerebrovascular hemorrhage</i> (A) IMMEDIATE CAUSE <i>Peritonitis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Perforation of duodenum and Peritonitis secondary to the above</i> (B) <i>Perforation of duodenum</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 1/4 hrs</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb 21</i> 19 <i>71</i> to <i>Feb 24</i> 19 <i>71</i> , that (I) (lost) lost saw the deceased alive on <i>Feb 24</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Daniel J. Powner, MD</i> | | 23B. DATE SIGNED <i>2/24/71</i> | | 23C. PHYSICIAN'S NAME (Type) _____ | |
| 23D. ADDRESS _____ | | 23E. DEGREE _____ | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2-27-71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Evergreen Mem. Gardens</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Farmington Md.</i> | | 24E. DATE REC'D BY HEALTH DEPT. _____ | | | |
| 25A. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25B. FUNERAL DIRECTOR <i>Paul E. Charney</i> | | 25C. ADDRESS <i>3617 Chestnut Ave.</i> | |

MAR 1 1971

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Letter from Union Memorial Hospital
4-13-71
M.H.

Walter L. Stein Jr.

"

0911-12-18

James L. Stein 814 W. 32nd St.

Walter L. Stein Jr.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2002

BIRTH NO. _____ REG. NO. _____

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) ALLIE IVORY | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour February 25, 1971 12:40 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3615 Park Heights Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year Hour February 25, 1971 12:40 A.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 7/2/15 | | 10. AGE (in years last birthday) 55 | |
| 11. BIRTHPLACE (State or foreign country) Ga. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY Private Homes | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 246 20 2487 | |
| 13. FATHER'S NAME Stokes Ivory | | 15. MOTHER'S MAIDEN NAME Jane Jones | |
| 18. INFORMANT Rosa L. Ivory | | ADDRESS 3615 Park Hgts. Ave | |
| 19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate M.D. | | DATE SIGNED February 25, 1971 | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/71 | |
| 24C. NAME of CEMETERY or CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Wm. I. Chatman, Jr. | |
| 25C. FUNERAL DIRECTOR 1701 McCulloh St. | | ADDRESS BALTO. MD. | |

VS 151-REV. 7/1/68

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UNITED STATES DEPARTMENT OF THE ARMY

ADJUTANT GENERAL

REPORT

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

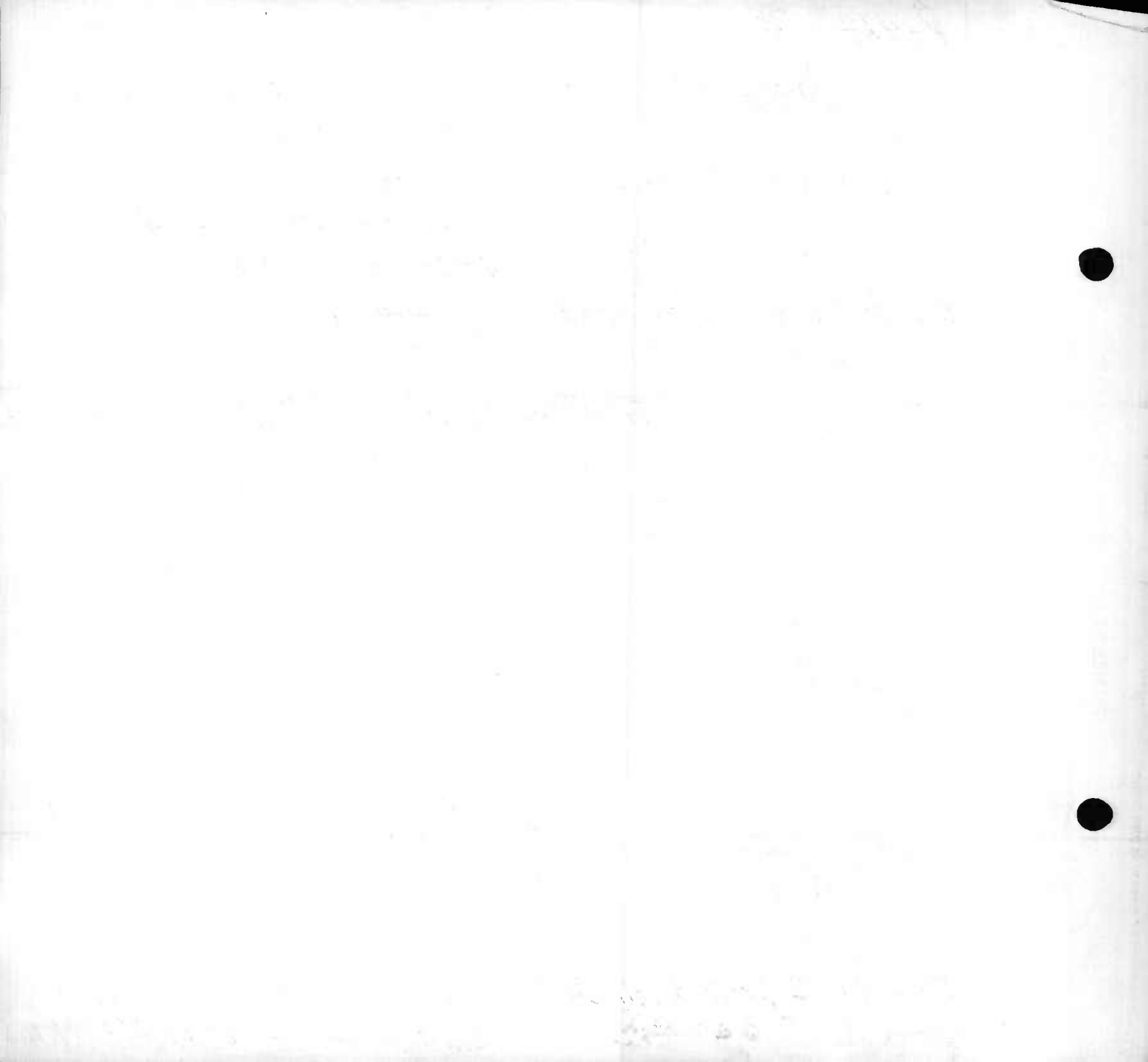
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2003 | |
|---|--|--|--|---|--|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Joseph Antkowiak | | 2. DATE AND HOUR OF DEATH Feb. 25, 1971 1:25 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore 5. CITY OR TOWN Balto Dundalk 6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 7. STREET AND NUMBER 7828 Kentley Rd | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 5-21-62 | | 9. AGE (In years last birthday) 8 | | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10B. KIND OF BUSINESS OR INDUSTRY Maryland | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Patrick Antkowiak | | | |
| 14. MOTHER'S MAIDEN NAME Loretta C. Kuhn | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT (Father) 7828 Kentley Rd. Mr. Patrick R. Antkowiak, Dundalk, Md. 21222 | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cardio respiratory arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral edema Possible Reye's Syndrome | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location) | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-21-1971 to 2-25-1971 that (I) (we) last saw the deceased alive on 2-25-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. A. Ziz | | | | 23B. DATE SIGNED 2/25/71 | |
| 23C. PHYSICIAN'S NAME (Type) S. A. Ziz | | | | 23D. ADDRESS Mercy Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/27/71 | | 24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | | |
| 25B. NAME of REGISTRAR John J. Duda | | 25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

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| P-462 71 2004 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | X 71 2004 | |
|---|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>George Wm Phillips</u> | | 2. DATE AND HOUR OF DEATH <u>2-24-71</u> <u>1:58P.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Cecil</u> 5721 | | C. CITY OR TOWN <u>Elkton</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>38 Univ. of Md Hospital</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>M</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>4-28-14</u> | | 9. AGE (In years lost birthday) <u>56</u> | | 10. Under 1 Yr. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> | | 11. BIRTHPLACE (State or foreign country) <u>Del.</u> | |
| 13. FATHER'S NAME <u>George Washington Phillips</u> | | 14. MOTHER'S MAIDEN NAME <u>Jennie Sawidge</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>717-079423</u> | | 17. INFORMANT <u>Margaret S. Phillips</u> ADDRESS <u>Elkton, Md.</u> | |
| 18. <u>441.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Dissection of Aorta secondary to Arteriosclerotic Aorta</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Chronic Arteriosclerotic Coronary Artery disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>2-24-71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-15</u> 19 <u>71</u> to <u>2-24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>2-24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>H. JAE Ihm MD</u> DEGREE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) <u>H. JAE Ihm MD</u> DEGREE | |
| 23D. ADDRESS <u>Univ. Hosp. & Md Hosp.</u> | | 23E. PHYSICIAN'S NAME (Type) <u>Paul P. Crough</u> ADDRESS | | 23F. PHYSICIAN'S NAME (Type) <u>Paul P. Crough</u> ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>2-28-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>North East Methodist</u> | |
| 24D. LOCATION (City, town, or county) <u>North East</u> | | 24E. LOCATION (City, town, or county) <u>Md</u> | | 24F. LOCATION (City, town, or county) <u>Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Grand Funeral Home</u> ADDRESS <u>North East Md</u> | |



B-652 71 2005 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 2005

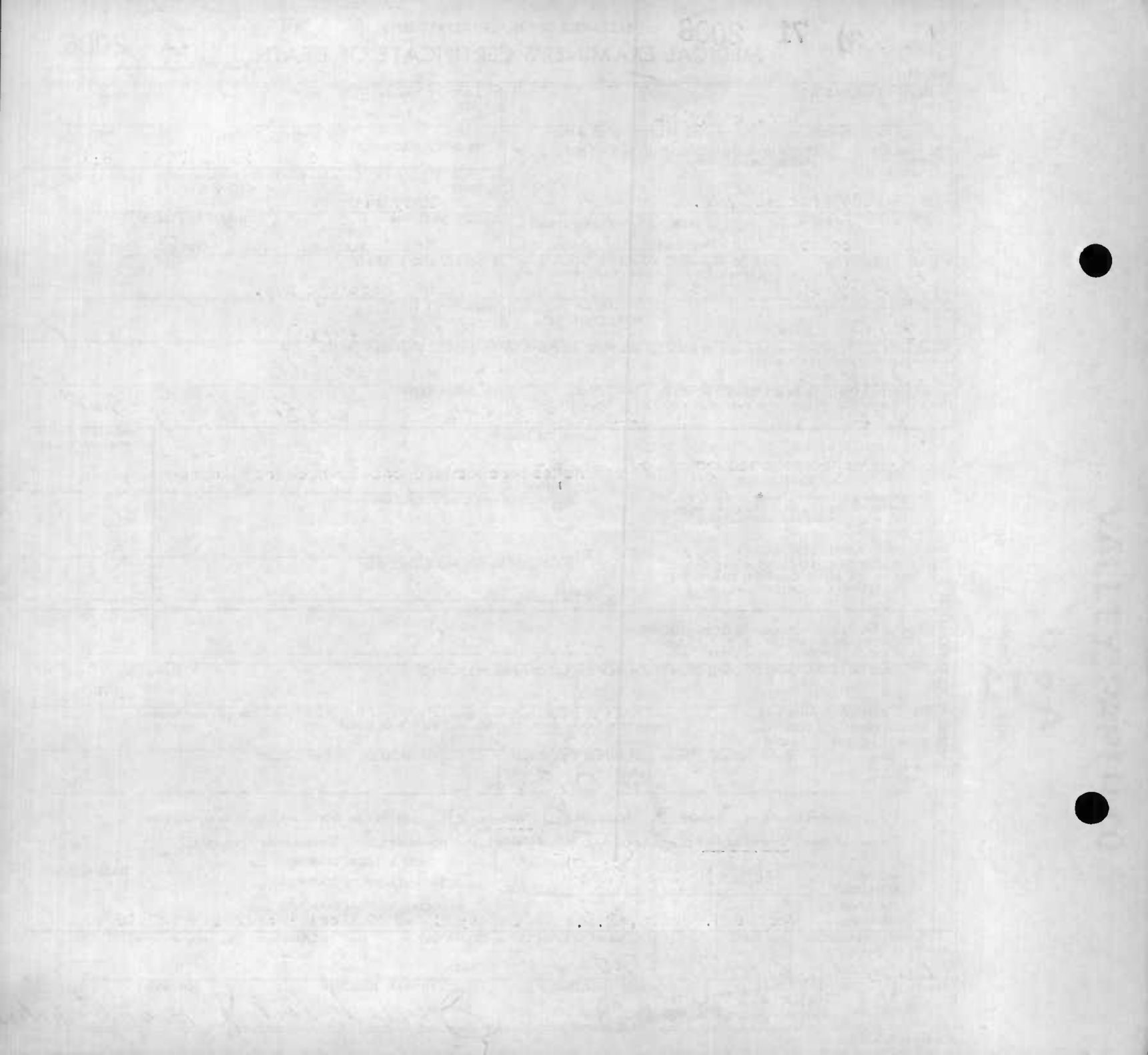
| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) VERA J. BARNES | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year Hour February 20, 1971 1:20 P. M. | |
| 6. SEX Female | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 4-21-52 | | 10. AGE (In years lost birthday) 18 | |
| 11. BIRTH PLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT | | 15. MOTHER'S MAIDEN NAME HELENA JENNING | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT John A. Barnes | | ADDRESS 2540 Cecil Ave | |
| 19. CAUSE OF DEATH 304.71 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Narcotics addiction DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 2/21/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/27/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus mem. PK | | 24D. LOCATION (City, town, or county) (State) Arbutus, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Joseph B. Lock | | ADDRESS 1304 N. Central Ave | |

ACADEMY BOND

AS CO. INC.

VALLEY PARK, MO.

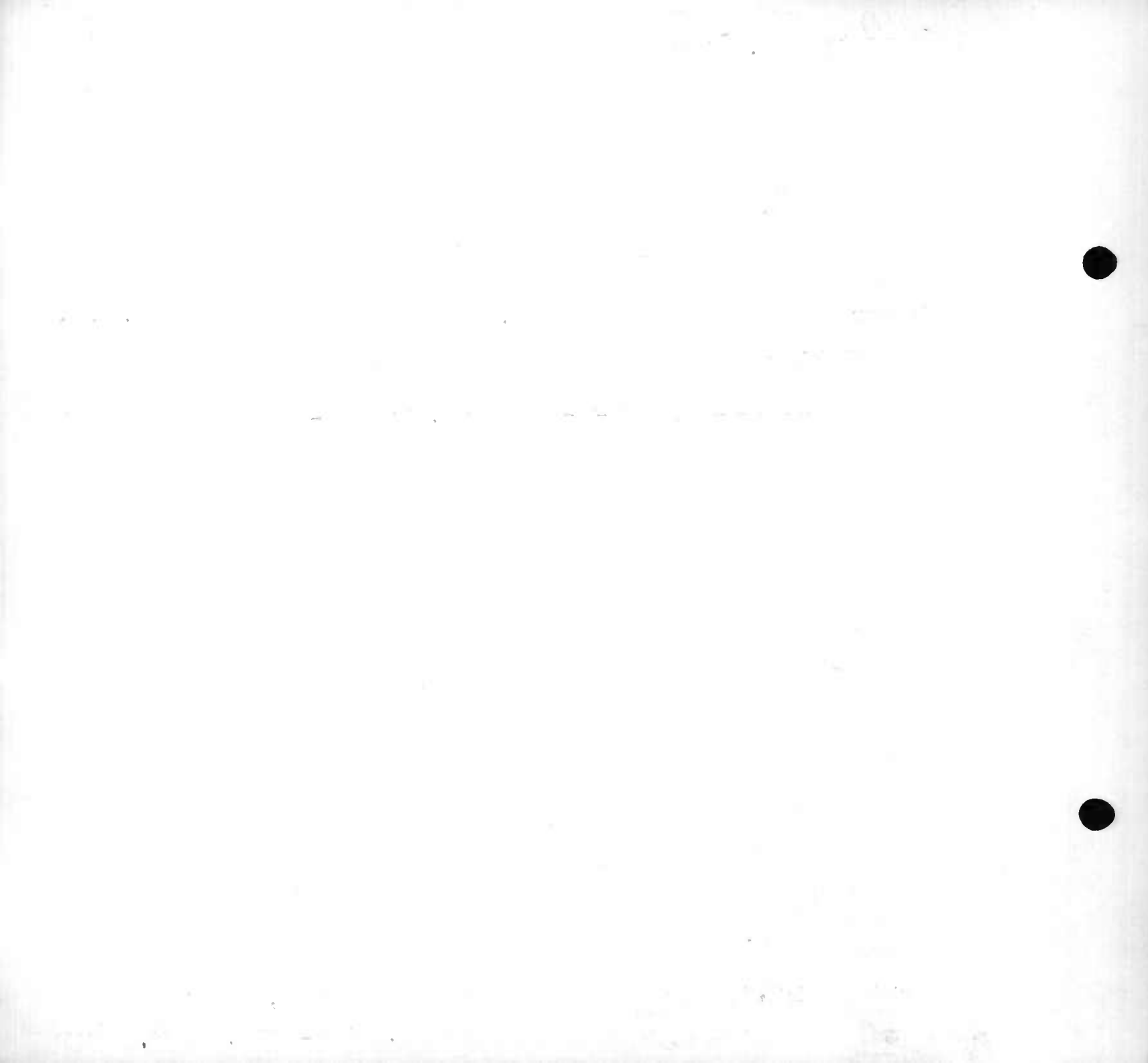
| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) George Lyles | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 604 Bartlett Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 26 71 8:18 p.m. | |
| 6. SEX male | | 7. RACE colored | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 7/27/22 | | 10. AGE (in years lost birthday) 48 | |
| 11. BIRTHPLACE (State or foreign country) Balt. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME George Lyles | | 14. MOTHER'S MAIDEN NAME Hattie White | |
| 15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland | | B. COUNTY 908 | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES | | 17. SOCIAL SECURITY NO. 215-72-3530 | |
| 18. INFORMANT Hattie Lyles | | ADDRESS 481 Schantz and | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. DATE SIGNED 2/27/71 EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/71 | |
| 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Balt. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Joseph B. Locks | |
| 25C. FUNERAL DIRECTOR 1304 N. Central | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2007 | |
|--|--|--|--|----------------------|------------------------------------|
| K-260 71 2007 BIRTH NO. Victor W. Kaiser | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Kaiser Victor W | | | 2. DATE AND HOUR OF DEATH 2-27-71 7:00 AM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Md. Gen. Hospital. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 101 | | |
| 5. SEX M 6. RACE Cauc. | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-22-86 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10B. KIND OF BUSINESS OR INDUSTRY American Smelting Co. | | 9. AGE (in years last birthday) 84 |
| 11. BIRTHPLACE (State or foreign country) Czechoslovakia | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Karl Kaiser | | | 14. MOTHER'S MAIDEN NAME Theresa ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212-10-2035 | | |
| 17. INFORMANT Anna E. Jaworski - 333 Ida Avenue #21221 | | | ADDRESS | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 2-9-71 to 2-27-71 that (I) (we) last saw the deceased alive on 2-26-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE W. Houghton MD 23B. DATE SIGNED 2-27-71 23C. PHYSICIAN'S NAME (Type) HOUGHTON 23D. ADDRESS MD GEN. HOSPITAL 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3/2/71 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231 25D. ADDRESS | | | | | |



BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SALVATORE A CARNAGGIO

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00117 S. Broadway

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

February 28, 1971

2:39 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

202

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

6/19/1906

10. AGE (In years
last birthday)

64

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

117 S. Broadway

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Francesco Carnaggio

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Taxi Driver

14B. KIND OF BUSINESS OR INDUSTRY

Taxi

15. MOTHER'S MAIDEN NAME

Sarah Carnaggio

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

114-03-0137 H

18. INFORMANT

Anthony J. Carnaggio 475 N. 1st St.

ADDRESS

19. 412.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHII
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month)

(Day)

(Year)

(Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Deputy Chief Medical Examiner 2/28/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

3/4/71

24C. NAME OF CEMETERY or CREMATORY

New Path

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT

MAR 1 1971

25B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

25C. FUNERAL DIRECTOR

Frank D. Vee 322 S. High St.

ADDRESS

IN SENATE
JANUARY 15, 1908

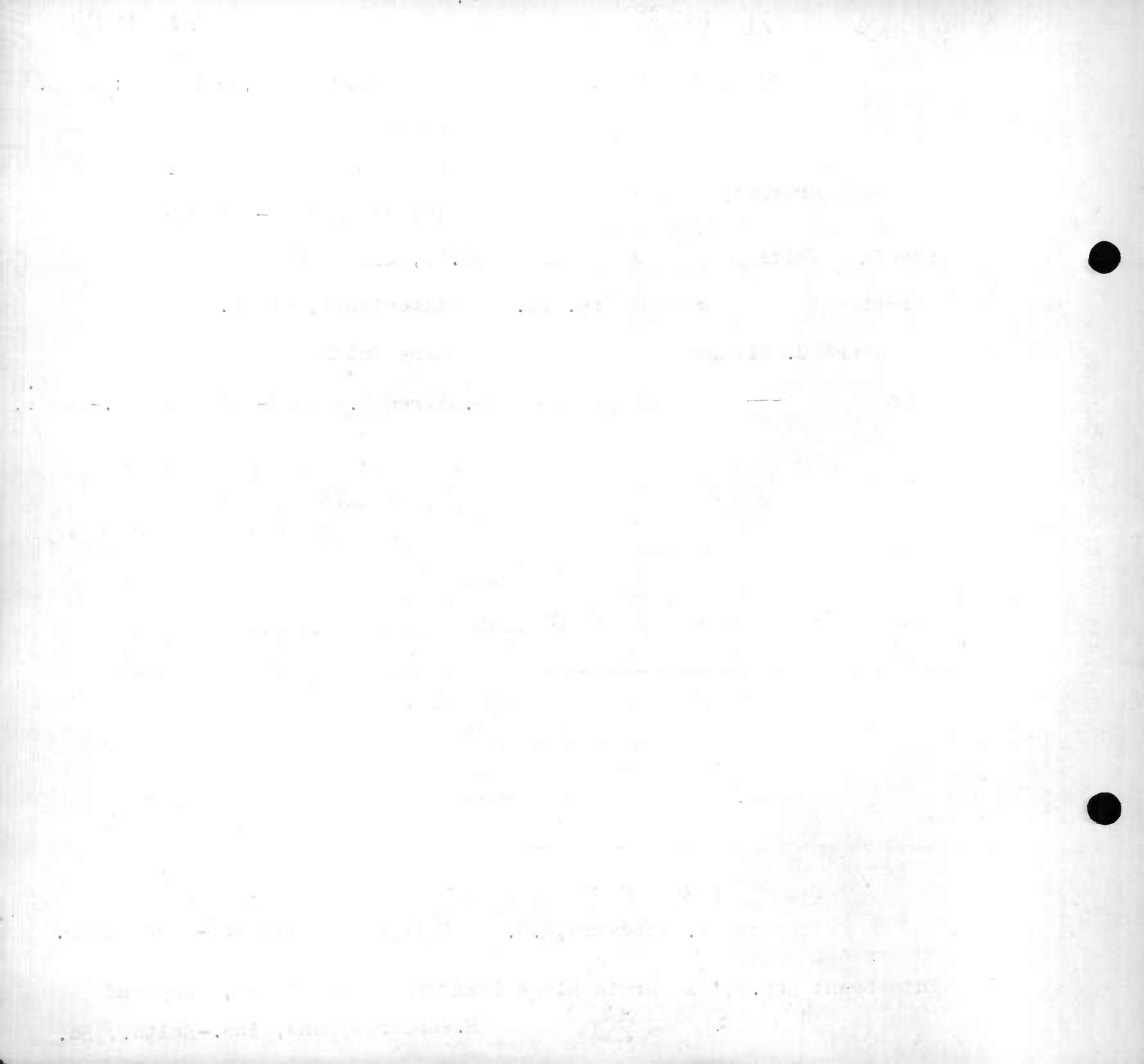
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1907

ALBANY:
J.B. LIPPINCOTT & CO. PRINTERS
1908

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2009 | |
| BIRTH NO. W-362 71 2009 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) SARA ANDERSON WHITEHURST | | 2. DATE AND HOUR OF DEATH February 25, 1971 7:30 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4101 Greenway | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1201 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4101 Greenway - 21218 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 30, 1890 |
| 9. AGE (In years last birthday) 80 | | 10. CITIZEN OF WHAT COUNTRY? USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President | | 10B. KIND OF BUSINESS OR INDUSTRY Machine Mfg. Co. | |
| 11. BIRTHPLACE (State or foreign country) Philadelphia, Penna. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Edward C. Brough | | 14. MOTHER'S MAIDEN NAME Mary Smith | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217 56 8244 | |
| 17. INFORMANT Mr. Alfred W. Brough-932 Urrh St.-Phila. Pa. | | ADDRESS | |
| 18. 43791 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerosis - generalized, severe | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 3 years | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 19 53 to FEB 25 19 71 , that (I) (we) last saw the deceased alive on FEB 24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Theodore E. Woodward M.D. | | 23B. DATE SIGNED FEB. 26, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) Theodore E. Woodward, M.D. | | 23D. ADDRESS University Hospital- 2nd Floor. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Entombment | | 24B. DATE Mar. 2, '71 | |
| 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT. MAY 1, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR H. Sander & Sons, Inc.-Balto., Md. | | ADDRESS | |



71 2010 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2010

E-663

BIRTH NO.

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) ELIAS HYDE EHRHART GEORGE EHRHARDT | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If in hospital or institution, give street address or location) 877 N. Howard Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour February 24, 1971 11:00 A.M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1102 | | | |
| 6. SEX Male | 7. RACE White | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH Jul. 15, 1914 | | 10. AGE (In years lost birthday) 56 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME Nettie Weedon | | 13. FATHER'S NAME George Ehrhart | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII | | 17. SOCIAL SECURITY NO. 215-09-4834 | |
| 18. INFORMANT Mrs. Regina N. Pong (daughter) | | ADDRESS 161 B. Pawhattan Beach, Glenburnie Md. | |
| 19. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fatty metamorphosis of liver | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/24/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar. 1, 1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. | | ADDRESS Baltimore Md. | |

VS 151-REV. 1/1/68

THE COMMUNITY VALLEY LABOR

March 1, 1971
Baltimore County
Baltimore, Md.

Dear Sirs:

I am writing to you regarding the matter of the proposed new contract for the employees of the Baltimore County Department of Social Services.

The proposed contract, which was submitted to the County Board of Commissioners on January 15, 1971, contains several provisions which are not in the interest of the employees.

One of the major provisions of the proposed contract is the elimination of the cost-of-living adjustment (COLA) clause which has been a part of the contract since 1964.

The elimination of the COLA clause would result in a significant decrease in the salaries of the employees, and this is not in the interest of the employees.

I am sure that you will agree that the employees should be able to maintain their standard of living, and the COLA clause is a necessary provision for this purpose.

FUNERAL DIRECTOR: IMPORTANT

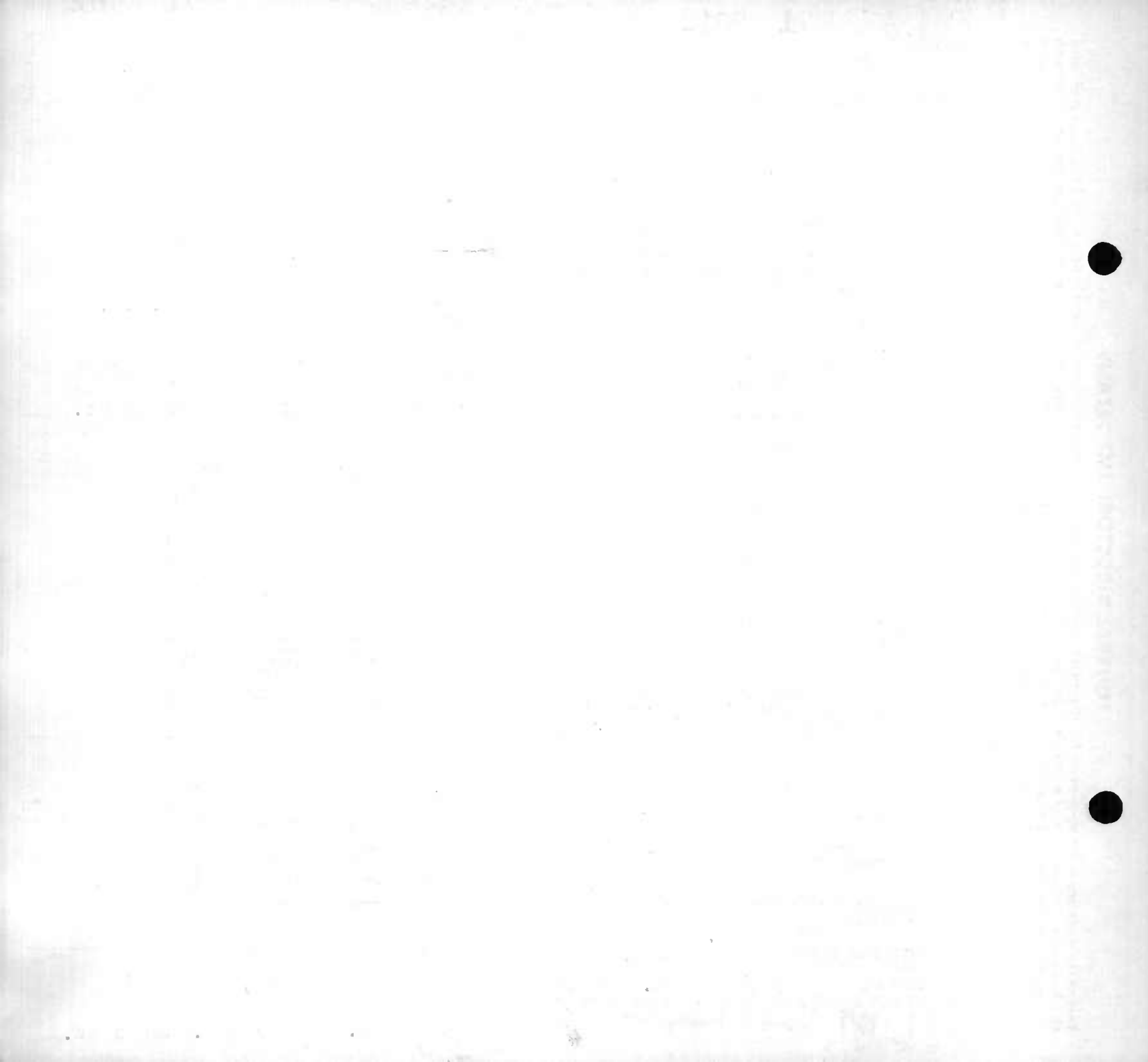
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2011</u> | |
|--|---------------------|---|---|--|---|
| C-500 71 2011 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. <u>C-500</u> | | 1. NAME OF DECEASED (Type or Print) <u>BLANCHE NEIL COAN</u> | | 2. DATE AND HOUR OF DEATH <u>2/26/71</u> <u>1</u> <u>2</u> AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1802</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MARYLAND HOSPITAL</u> <u>38</u> | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>101 Carrollton</u> <u>21217</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5/9/99</u> | 9. AGE (In years last birthday) <u>71</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>South Carolina</u> | |
| 13. FATHER'S NAME <u>Lee Grant Neil</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mattie Craig</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Albert Coan</u> ADDRESS <u>21217</u> <u>1101 Carrollton Ave</u> | |
| 18. <u>436.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u> <u>1 1/2 years</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>2/22</u> 19 <u>71</u> to <u>2/26</u> 19 <u>71</u> that (2) (we) last saw the deceased alive on <u>2/26</u> 19 <u>71</u> and that (3) (we) (our) applan death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>J. E. Mahaffey M.D.</u> | | | | 23B. DATE SIGNED <u>2/26/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>J. E. MAHAFFEY M.D.</u> | | | | 23D. ADDRESS <u>University of Maryland Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>3-2-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Arbutus Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Robert E. Taylor</u> ADDRESS <u>21217</u> <u>1701 Laurens St</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>C-615</u> <u>71</u> <u>2012</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2012 | | CERTIFICATE OF DEATH | | REG. NO. _____ | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>MARGARET CORBIN</u> | | | | 2. DATE AND HOUR OF DEATH <u>5 AM 2/28/71 2/971</u> M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY 2543</u> | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 THE JOHNS HOPKINS HOSPITAL</u> | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| E. STREET AND NUMBER <u>2427 ANNOR COURT</u> | | | | | | | | | | | |
| 5. SEX <u>FEMALE</u> | | 6. RACE <u>NEGRO</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-21-42</u> | | 9. AGE (In years last birthday) <u>28</u> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>WELTON BAILEY</u> | | | | 14. MOTHER'S MAIDEN NAME <u>FRANCES FIELDS</u> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Frances McKnight 2412 Dorton Ct.</u> | | ADDRESS <u>2412 Dorton Ct.</u> | | | |
| 18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Cervix</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>1 year</u> | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Cervix</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/4</u> 19 <u>71</u> to <u>2/28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>5 AM 2/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>Richard J. Kates MD</u> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>2/28/71</u> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>RICHARD J. KATES</u> | | | | 23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/5/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Kelley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> | | ADDRESS <u>661 W. Barre St.</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 2013 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2013 | |
|---|---------------------|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>OTIS Stewart</u> | | | 2. DATE AND HOUR OF DEATH <u>2-26-71</u> <u>12:15 A</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2720 Harlem Ave</u> <u>21217</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/26/44</u> | 9. AGE (In years last birthday) <u>26</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>George Stewart</u> | | | 14. MOTHER'S MAIDEN NAME <u>-</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u> | | 16. SOCIAL SECURITY NO. <u>215-07-15430</u> | | 17. INFORMANT <u>Viola Stewart</u> ADDRESS <u>2720 Harlem</u> | |
| 18. <u>482.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Klebsiella Septicemia</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Also Klebsiella pneumoniae</u> <u>Massive Gastrointestinal Bleeding</u> <u>Disseminated Intravascular Coagulation</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>due to</u> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>Feb 17</u> 19 <u>71</u> to <u>Feb 26</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>Feb 26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>R. C. Allen</u> | | | 23B. DATE SIGNED <u>Feb 26, 1971</u> | | 23C. PHYSICIAN'S NAME (Type) <u>A. C. AKENZATOS, M.D.</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>3/3/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1971</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> ADDRESS <u>66 W. Burre</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

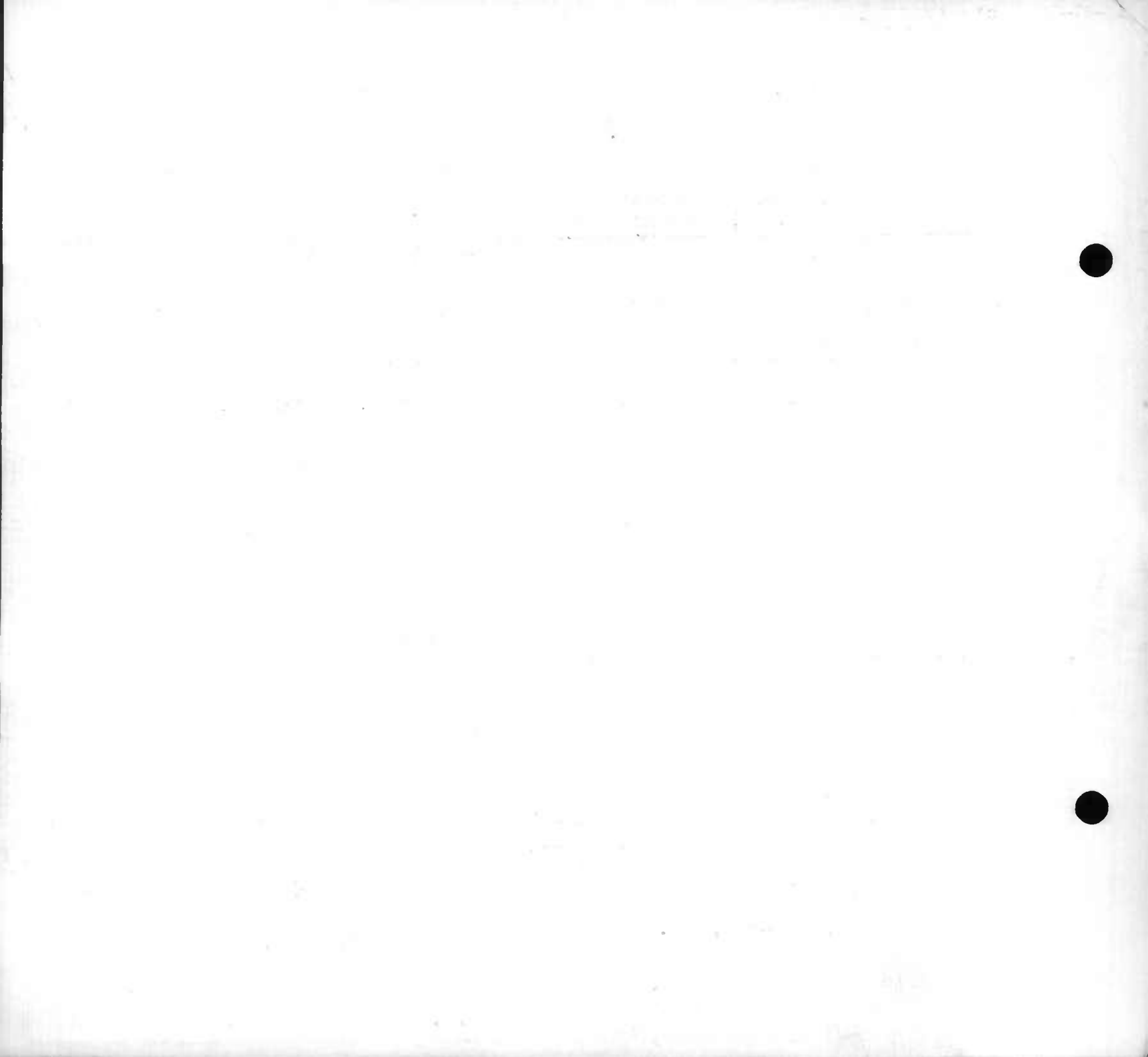
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2014</u> | |
|---|----------------------------|---|--|---|--|
| 7-622 71 2014 BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Harry Ferguson</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>91 Montabello Hospital</u> | | 2. DATE AND HOUR OF DEATH <u>2/25/71</u> <u>8:15</u> P.M. 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1802</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1072 W. FAIRMOUNT Ave 21223</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/10/1897</u> | 9. AGE (in years last birthday) <u>72</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Jack Ferguson</u> | | | 14. MOTHER'S MAIDEN NAME <u>Hannah</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW I</u> | | 16. SOCIAL SECURITY NO. <u>212-18-3932</u> | | 17. INFORMANT <u>Laura Daniels</u> ADDRESS <u>1073 W. FAIRMOUNT Ave</u> | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>412.31 CVA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCD</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Old myocardial infarction</u> | | | | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>2/10</u> 19 <u>70</u> to <u>2/25</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>19</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Marc A. Goldberg MD</u> | | | | 23B. DATE SIGNED <u>2/25/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MARC A. GOLDBERG MD</u> | | | | 23D. ADDRESS <u>Montebello State Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/2/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>McCuburn</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Charles E. Rice</u> ADDRESS <u>6614 Bann</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-352 71 2015 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2015 | |
|---|--|---|--|---|--|---|--|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Butenko, Olena | | | | 2. DATE AND HOUR OF DEATH 2-26-71 735 pm. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | A. STATE Maryland | | | |
| | | | | B. COUNTY | | | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 524 S. Belnord Avenue | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-20-97 | |
| | | | | 9. AGE (in years last birthday) 73 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10B. KIND OF BUSINESS OR INDUSTRY Food Packing | | 11. BIRTHPLACE (State or foreign country) Ukraine | |
| 13. FATHER'S NAME Simon Semonenko | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - - - 21 | | | | 6. SOCIAL SECURITY NO. 5-30-1976 | | 17. INFORMANT BCH RECORDS: 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 18. 25091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Diabetes mellitus | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH many years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Urinary tract infection - ASCVD - | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (we) (this hospital) attended the deceased from 12-11 19 70 to 2-26 19 71 that (I) (we) last saw the deceased alive on 2/26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Henry Herrea M.D. | | | | 23B. DATE SIGNED 2/26/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) Henry Herrea, M.D. | | | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/71 | | 24C. NAME OF CEMETERY or CREMATORY St. Andrew | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Charles J. ... | | 25C. FUNERAL DIRECTOR M. F. SABOWSKI & SONS, 1808 EASTERN AVE | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

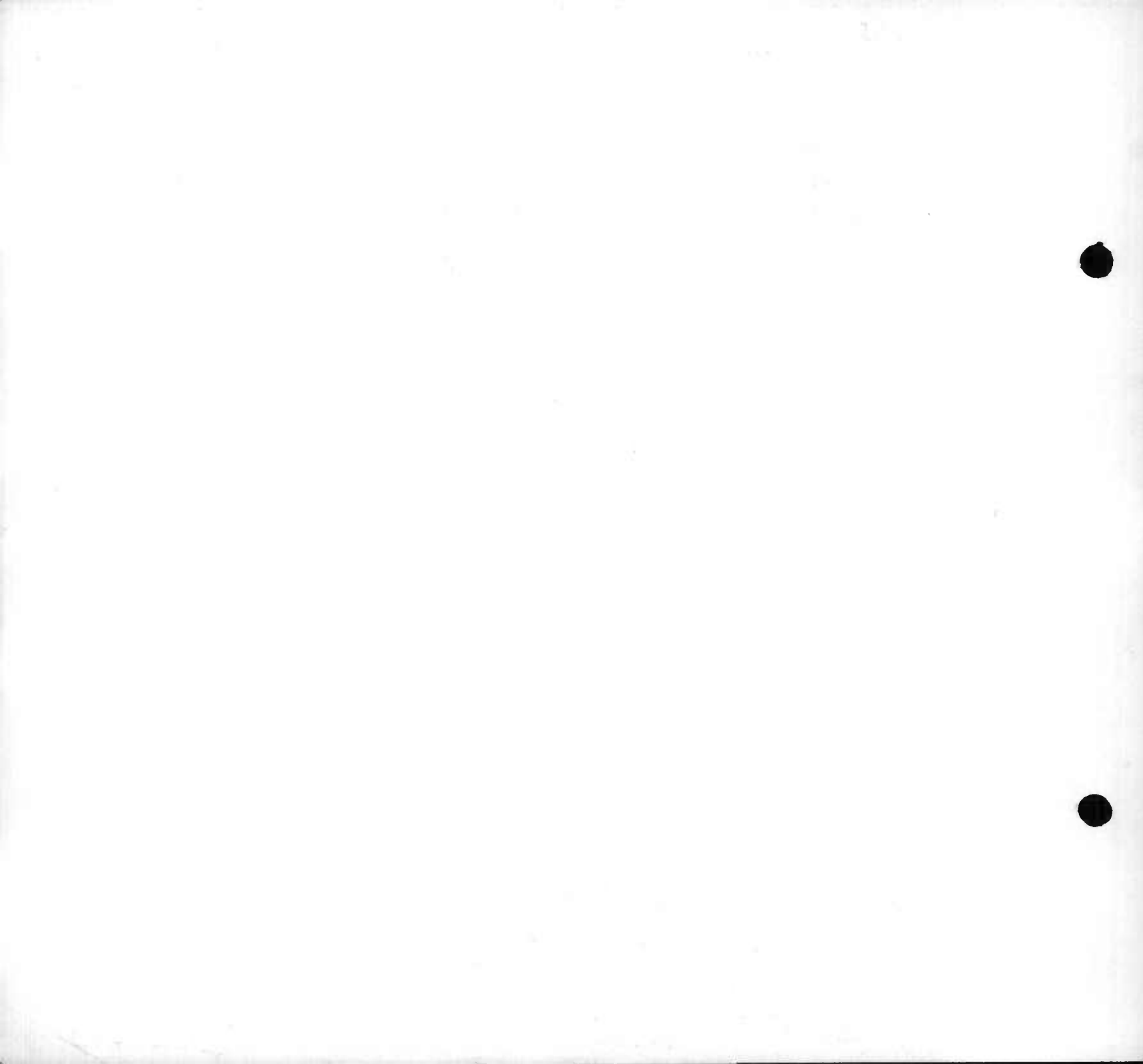
| BIRTH NO. | | 371 2016 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2016 | | |
|--|--------------|---|-----------------------------------|---|--|---|-------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) Glenn, Audrey Mae | | | | 2. DATE AND HOUR OF DEATH 2-26-71 8:00 P. M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1506 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2926 Westwood Avenue 21216 | | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 12-29-32 | 9. AGE (in years last birthday) 38 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unempl. | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jesse - deceased | | | | 14. MOTHER'S MAIDEN NAME Hazel - deceased | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BCH RECORDS: 4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 18. 57101 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (A) IMMEDIATE CAUSE - Liver failure DUE TO, OR AS A CONSEQUENCE OF: - gram negative sepsis (B) - Multiple clothing deformities DUE TO, OR AS A CONSEQUENCE OF: - cirrhosis, chronic alcoholism (C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 11-30-1970 to 2-26-1971 that (X) (we) last saw the deceased alive on 2/26/71 8:15 PM and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | | |
| 23A. SIGNATURE P. S. S. HACHARY MD DEGREE | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) P. S. S. HACHARY MD DEGREE | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE 3-3-71 | | 24C. NAME OF CEMETERY OR CREMATORY Wake Co. N.C. | | 24D. LOCATION (City, town, or county) (State) Raleigh, N.C. | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR John M. Johnson | | ADDRESS 3401 Fairview Ave 16 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|--|--|--|--|---|--|
| BIRTH NO. N-200 | | 71 2017 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2017 | |
| 1. NAME OF DECEASED (Type or Print) William Lee Nash | | | | 2. DATE AND HOUR OF DEATH Feb 23, 1971 3:05 p.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1703 | | | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 412 Myrtle Ave. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10/29/1894 | 9. AGE (In years last birthday) 76 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME ?? | | | |
| 14. MOTHER'S MAIDEN NAME ?? | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I | | | |
| 16. SOCIAL SECURITY NO. 220-0 3-309 | | | | 17. INFORMANT Marion Stern | | | |
| 18. 2/10/71 | | | | ADDRESS 412 Myrtle Ave. | | | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute myocardial infarction | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/21 19 71 to 2/23 19 71 that (I) (we) last saw the deceased alive on 2/23 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE R. Tsukamoto, M.D. | | | | 23B. DATE SIGNED 2/23/71 | | 23C. PHYSICIAN'S NAME (Type) R. Tsukamoto M.D. | |
| 23D. ADDRESS Maryland General Hospital | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/71 | |
| 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery | | | | 24D. LOCATION (City, town, or county) (State) A A County Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | |
| 25B. NAME OF REGISTRAR Phyllis Halstead | | | | 25C. FUNERAL DIRECTOR 1206 W North Ave | | 25D. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 71 2018 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2018 | | REG. NO. | |
|---|---------------------|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>Mary Agnes Medley</i> | | | | 2. DATE AND HOUR OF DEATH <i>Feb 26 1971 1:55 P.M.</i> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospitals</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <i>Maryland - Baltimore</i> | | B. COUNTY | | C. CITY OR TOWN <i>Baltimore</i> | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER <i>1024 W. Saratoga St.</i> | | F. NO. <i>1802</i> | |
| 5. SEX <i>F</i> | 6. RACE <i>N</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>4/21/88</i> | | 9. AGE (in years last birthday) <i>82</i> | | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>St. Marys Co. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | |
| 13. FATHER'S NAME <i>William Medley</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Lizette Ellen Medley</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Deloris Marion 1024 W. Saratoga St.</i> | | | |
| 18. <i>15601</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH <i>CARCINOMA OF THE GALL BLADDER</i> (A) IMMEDIATE CAUSE <i>Histocarcinoma</i> DUE TO, OR AS A CONSEQUENCE OF: <i>No Decadent mustered neoplasia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb 26</i> 19 <i>71</i> to <i>Feb 26</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>Feb 26</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Richard A. Cash MD</i> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>Feb 26 1971</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Richard A. Cash MD</i> | | | | 23D. ADDRESS <i>University of Maryland Hospitals</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>3/1/71</i> | | 24C. NAME OF CEMETERY OR CREMATOR <i>Wt. Auburn Cem.</i> | | 24D. LOCATION (City, town or county) (State) <i>Balto. Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>W. E. Jones</i> | | 25C. FUNERAL DIRECTOR <i>William's Funeral Home</i> | | ADDRESS <i>3912 Broadway St.</i> | | | |

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B569 2019

BALTIMORE CITY HEALTH DEPARTMENT

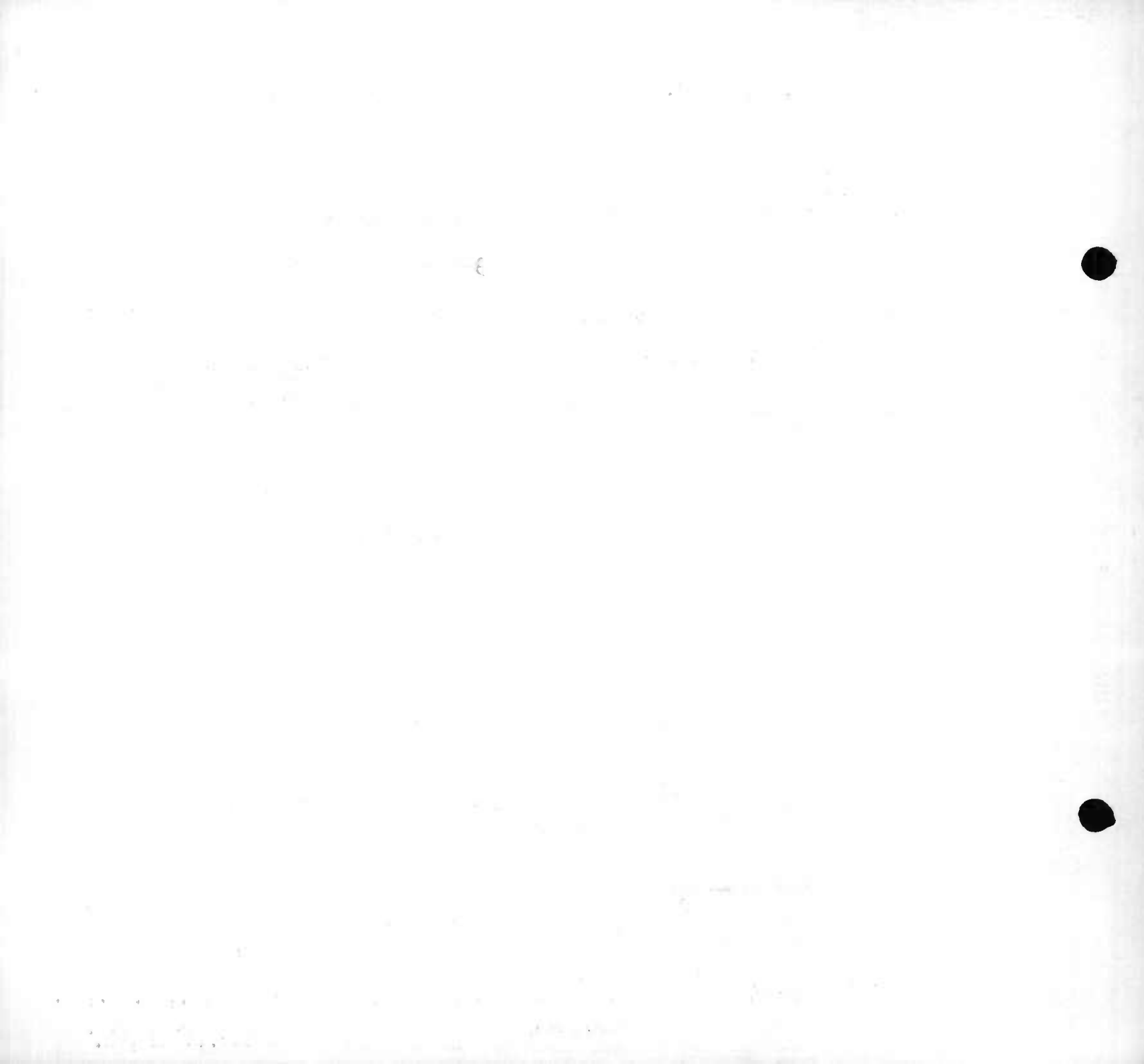
CERTIFICATE OF DEATH

REG. NO. 71 2019

| | | | | | |
|---|------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Benner, Lillian T. | | February 26, 1971 4:55 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | A. STATE Maryland B. COUNTY 2664 | |
| | | | | C. CITY OR TOWN Baltimore | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 9 North Kresson Street 21224 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-24-02 | 9. AGE (In years last birthday) 68 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Ernest Schluter | | | | 14. MOTHER'S MAIDEN NAME Julia Naumann | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No | | 16. SOCIAL SECURITY NO. 219-12-7930 | | 17. INFORMANT BCH: Redords Baltimore, Maryland 21224 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF: ! Act | | | | | |
| (B) Chronic Nephritis → uraemia DUE TO, OR AS A CONSEQUENCE OF: Pleural Effusion: Dependent | | | | | |
| (C) | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH [] Inotify medical examiner | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-21 19 71 to 2-26 19 71 that (I) (we) last saw the deceased alive on 2/26/ 19 71 4:55 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE P. Seshachary MD | | | | 23B. DATE SIGNED February 26, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) P. SESHACHARY | | | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-1-71 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION 7225 Eastern Blvd., Ba. Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR 2018 | | 25D. ADDRESS 6224 Eastern Ave. Balto., 21224, Md. | |

FUNERAL DIRECTOR: IMPORTANT

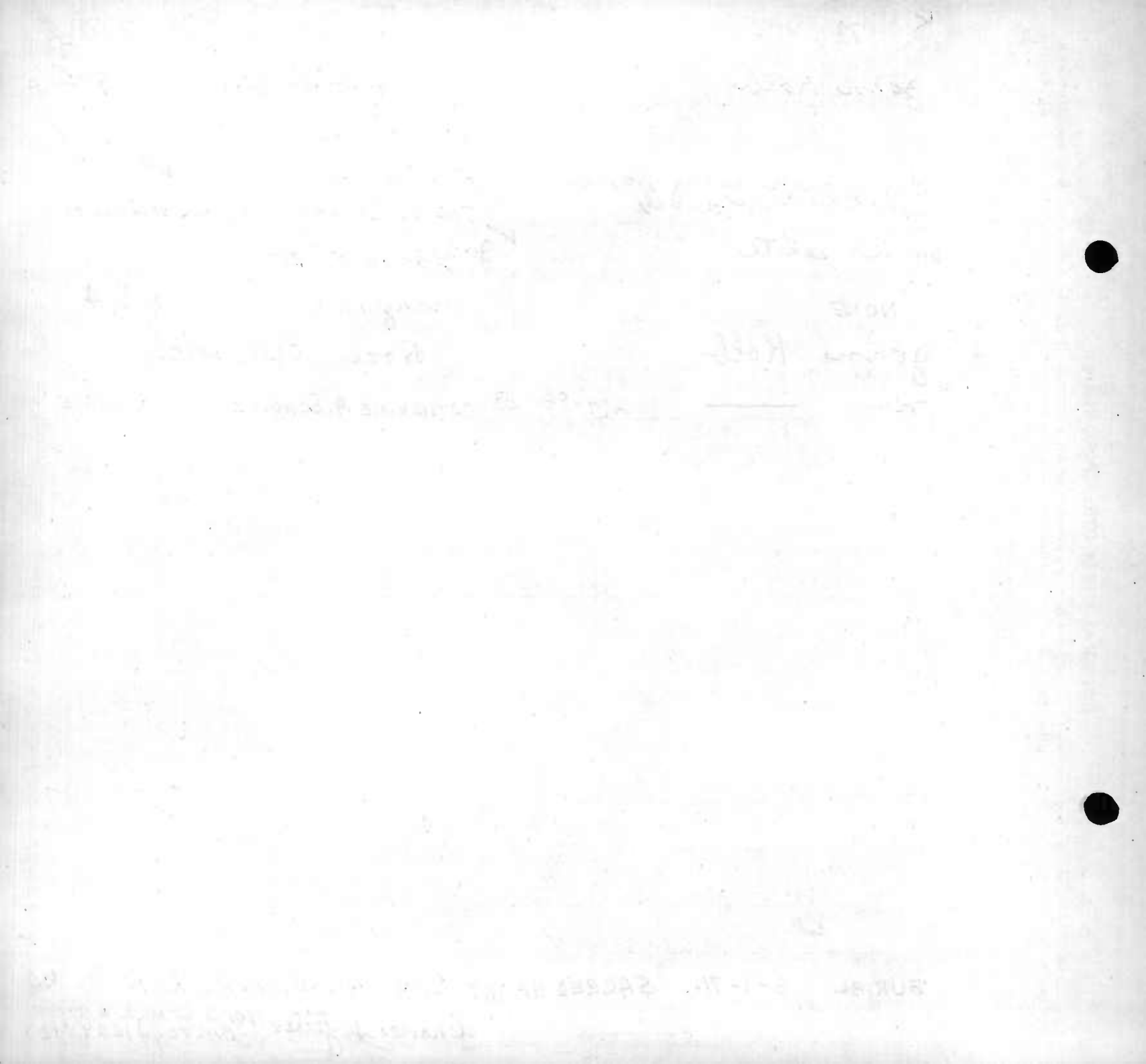
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

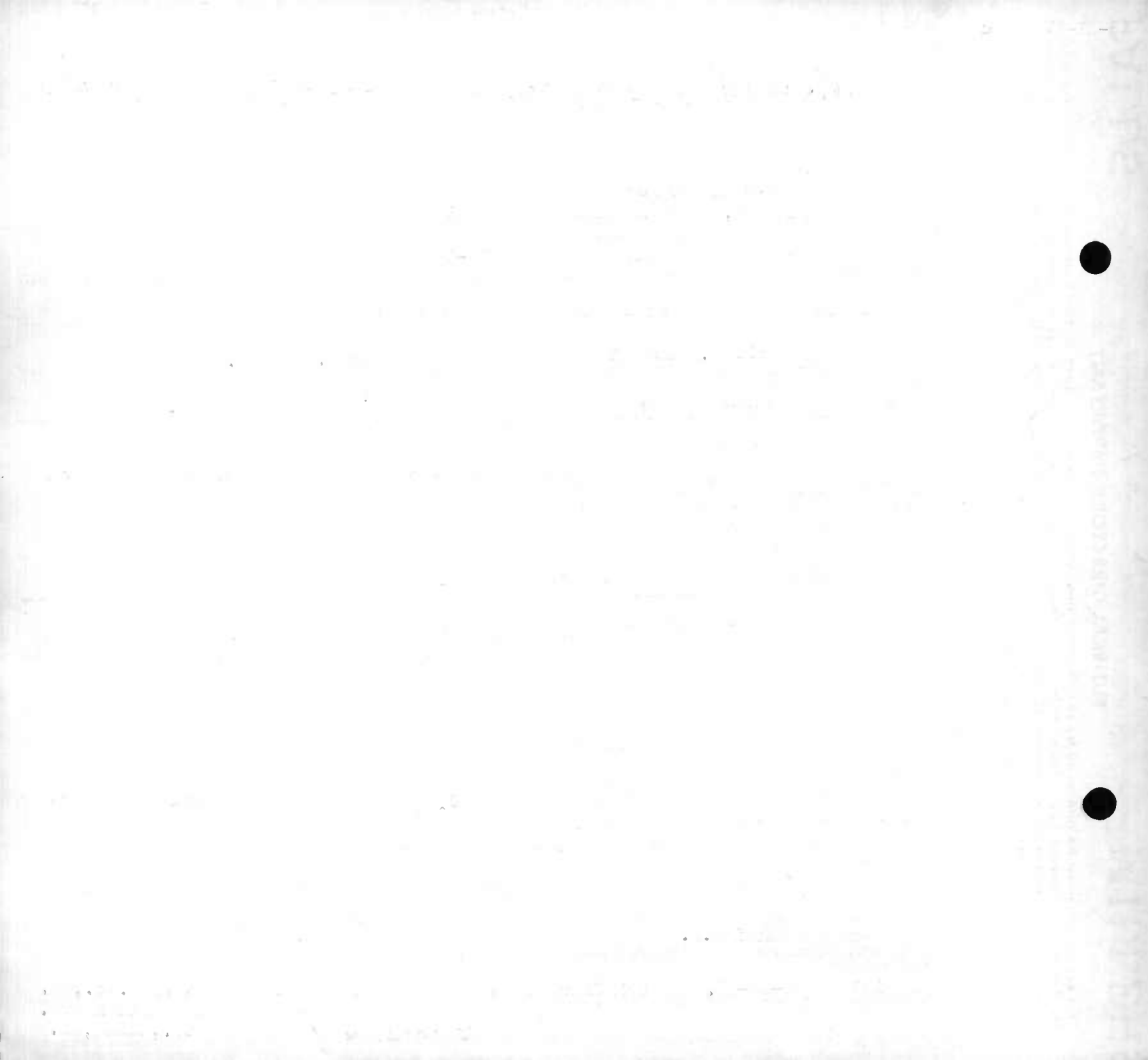
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71</u> <u>2020</u> | |
|---|----------------------|---|--|--|--|
| K 4191 2020 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>John Kolb</u> | | 2. DATE AND HOUR OF DEATH <u>Feb. 26, 1971.</u> <u>9:45</u> A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Harrison Nursing Home</u> <u>2803 Harrison Blvd</u> | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>101</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>712 S. Ellwood Ave. #21224</u> | | | |
| 5. SEX <u>male</u> | 6. RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 26, 1895</u> | 9. AGE (In years lost birthday) <u>75</u> | If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>John Kolb</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>214-565685</u> | | 17. INFORMANT <u>CATHERINE A. SCHULTZ</u> | |
| 18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CAUSE OF DEATH <u>possible congestive heart failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>due to ASD (acute)</u> (B) DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>years</u> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/26</u> 19 <u>46</u> to <u>2/26</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>2/26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Elijah Saunders</u> | | 23B. DATE SIGNED <u>2/26/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Elijah Saunders, MD</u> | |
| 23D. ADDRESS <u>2308 Harrison Blvd.</u> | | 23E. FUNERAL DIRECTOR <u>Charles H. Zeiler</u> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-1-71.</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD. BA. Co., MD</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>1971000</u> | | | |
| 25B. NAME OF REGISTRAR <u>1971000</u> | | 25C. ADDRESS <u>901 S. CONKLIN ST. BALTO., 21224, MD.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

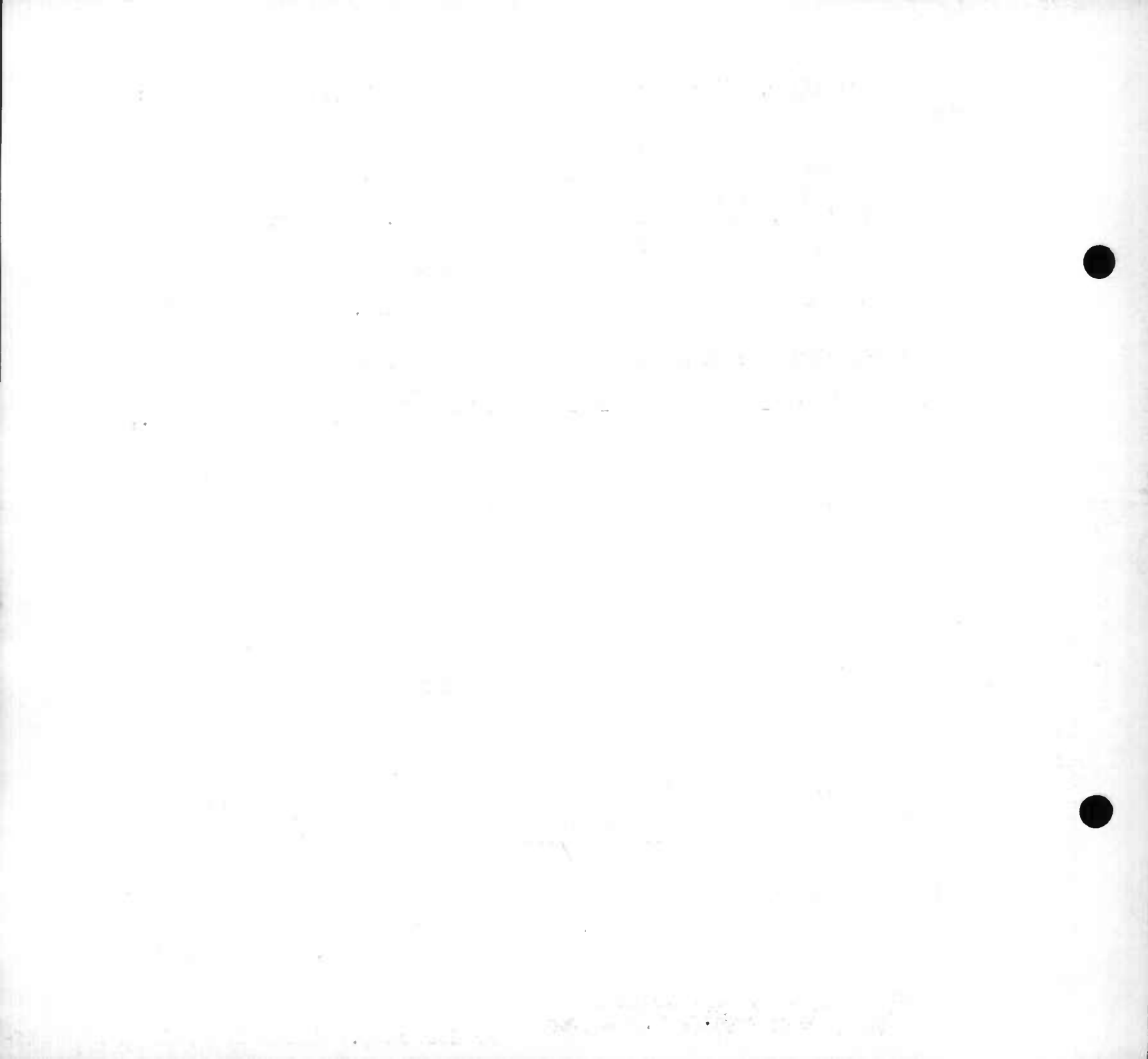
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2031 | |
|--|---|---|--|---|---|
| BIRTH NO. 543 71 2031 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Wienhold, Caroline, E.</i> | | 2. DATE AND HOUR OF DEATH <i>2/24/71 10:45 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-36</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224</i> | | C. CITY OR TOWN <i>Baltimore</i> | |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER <i>6212 Copore Way 21224</i> | | | |
| 5. SEX <i>female</i> | 6. RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>10-1-90</i> | 9. AGE (in years last birthday) <i>80</i> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>House Work</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>John F. Deckret</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary R. Probst.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | | 17. INFORMANT <i>BCH RECORDS: 4940 Eastern Avenue Baltimore, Md. 21224</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Subarachnoid Hemorrhage 4 days 2° to bleeding (consumption) Disorder</i> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Unilateral Hemiparesis, C.V.D. arthritis</i> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/23</i> 19 <i>71</i> to <i>2/24</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>2/24</i> 19 <i>71</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Mazzi</i> | | 23B. DATE SIGNED February 24, 1971 | | 23C. PHYSICIAN'S NAME (Type) <i>Eduardo Mazzi M.D.</i> | |
| 23D. ADDRESS <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i> | | 23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>2-27-71</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i> | 24D. LOCATION (City, town, or county) (State) <i>7225 Eastern Blvd., Ba. Co., Md.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR <i>971000</i> | 25C. FUNERAL DIRECTOR <i>Charles D. Gailer</i> | 6224 Eastern Ave. Balto., 21224, Md. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>S-246 71 2022</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>71 2022</u> | |
|--|-------------------------|---|-----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>Schuessler</u> | | | | 2. DATE AND HOUR OF DEATH <u>2/23/71</u> <u>1:20 P</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>701</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>625 N. Decker Street</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/9/01</u> | 9. AGE (in years last birthday) <u>69</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>John Schuessler</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Amelia Kirch</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>5/16/17 - 4/26/19</u> | | | | 16. SOCIAL SECURITY NO. <u>267-48-1811</u> | | 17. INFORMANT ADDRESS <u>VA Hospital Records</u> <u>3900 Loch Raven Boulevard Balto., Md 21218</u> | |
| 18. <u>710.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <u>W</u> (this hospital) attended the deceased from <u>February 20th</u> 19 <u>71</u> to <u>February 23rd</u> 19 <u>71</u> that <u>W</u> (we) last saw the deceased alive on <u>February 23rd</u> 19 <u>71</u> and that <u>W</u> (we) (our) opinion death occurred on the date and hour and from the causes stated above. <u>W</u> (We) (did) <u>did not</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Richard A. Baum D.D.</u> | | | | 23B. DATE SIGNED <u>2/24/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Richard A. Baum D.D.</u> | |
| 23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u> | | | | 23E. DATE <u>2/26/71</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. NAME OF CEMETERY OR CREMATORY <u>Crest Lawn</u> | | | |
| 24C. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1971</u> | | | | 24D. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | | |
| 24E. FUNERAL DIRECTOR <u>Frederick D. Miller Inc</u> | | | | 24F. ADDRESS <u>3019 Monument St</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2023 | |
|--|-------------------------|---|--|--|---|
| <div style="display: flex; justify-content: space-between;"> 71 2023 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) CARTER, DAISY | | | 2. DATE AND HOUR OF DEATH FEBRUARY 26, 1971 6:30 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1511 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION JEWISH CONVALESCENT & NURSING HOME 4601 PALL MALL ROAD BALTO. MD. 21215 | | | C. CITY OR TOWN BALTIMORE 21215 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | E. STREET AND NUMBER 3501 COPLEY ROAD | | |
| 5. SEX Female | 6. RACE Black | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 06/30/1898 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY Private Family | | 11. BIRTHPLACE (State or foreign country) ALABAMA | |
| 13. FATHER'S NAME Lorenzo Wilson | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 234-20-9860 D | | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | | 17. INFORMANT (daughter-in-law) Mary Carter 3501 Copley Rd. | | |
| 18. 41241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/5/70 | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular disease | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Generalized Osteoarthritis | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II | | | (C) DUE TO, OR AS A CONSEQUENCE OF: Unknown | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1969 to 2/26 71 , that (I) (we) last saw the deceased alive on 2/26 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE D. W. STEWART, M.D. | | | 23B. DATE SIGNED 2/26/71 | | 23C. PHYSICIAN'S NAME (Type) D. W. STEWART, M.D. |
| 23D. ADDRESS 2300 Garrison Blvd. | | | 23E. FUNERAL DIRECTOR Rudolph J. Collick | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE MAR 1 1971 | | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial PK | | | 24D. LOCATION (City, town, or county) (State) Arbutus, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | | 25B. NAME OF REGISTRAR Robert E. Jahn, M.D. | | |
| 25C. FUNERAL DIRECTOR Rudolph J. Collick | | | 25D. ADDRESS 2431 E. Oliver St. | | |

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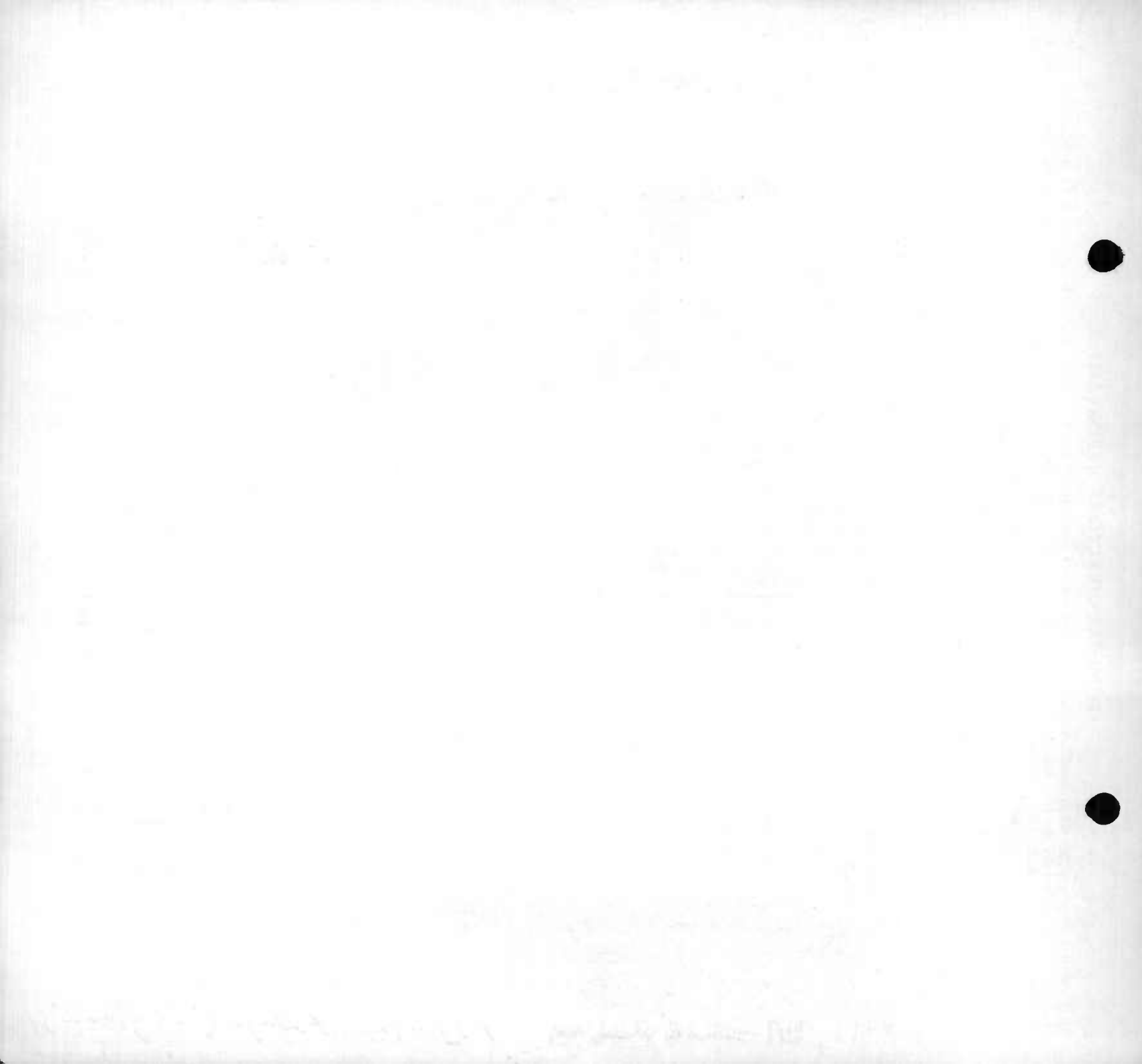
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

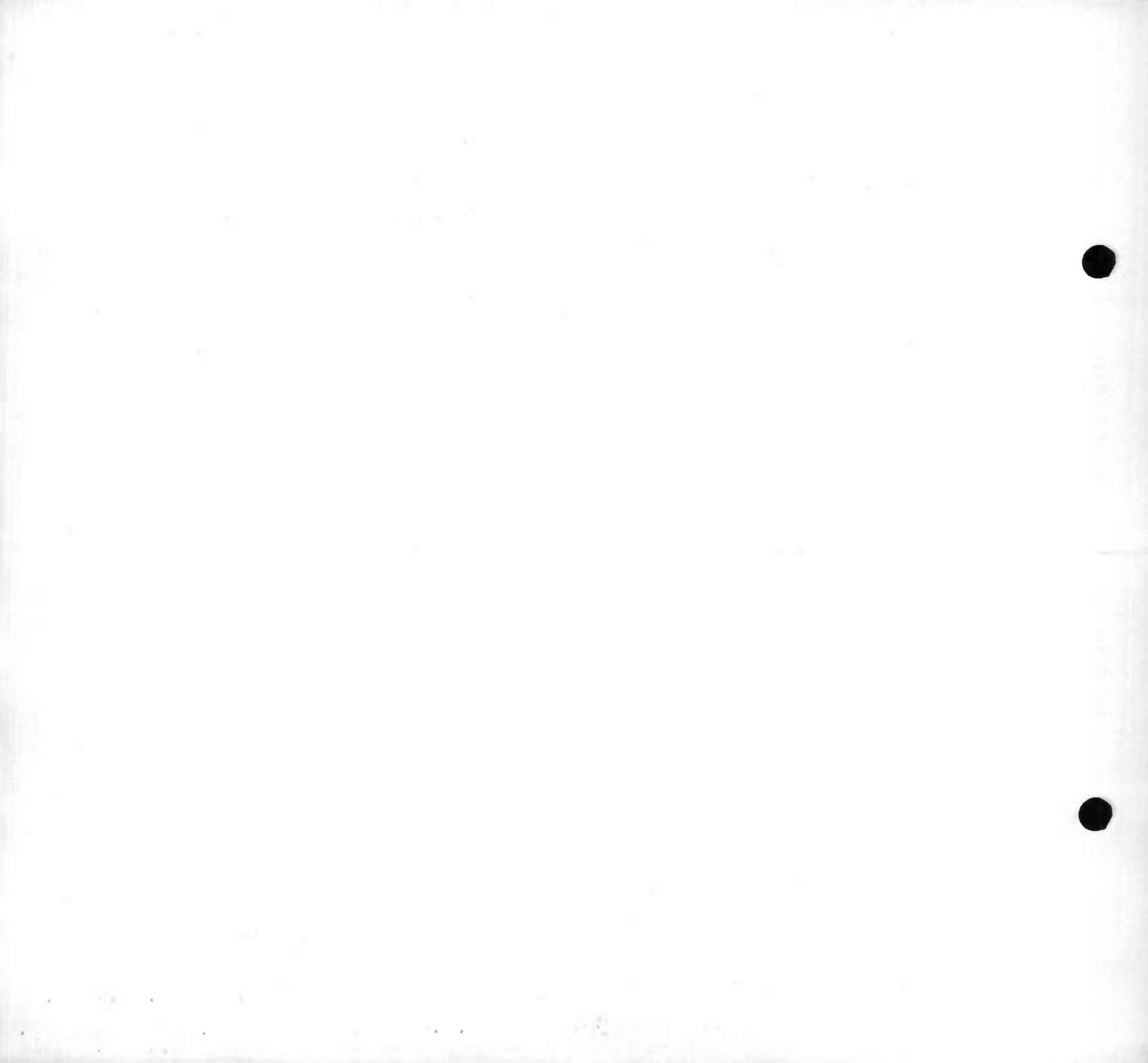
| BIRTH NO. 71 2024 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 71 2024 | |
|--|-------------------------|---|---|---|------------------------------|--|--------------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Classie Roundtree Mills</i> | | | | 2. DATE AND HOUR OF DEATH <i>2/27/71 10:05 P. M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1205</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>307 E. Lannale St. 21202</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>NEGRO</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOW</i> | 8. DATE OF BIRTH <i>July 4, 1905</i> | 9. AGE (In years last birthday) <i>65</i> | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>S.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>George Roundtree</i> | | | | 14. MOTHER'S MAIDEN NAME <i>NITA</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>minnie mills</i> | | | ADDRESS <i>307 E. Lannale St.</i> |
| 18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) <i>Acute myocardial infarction</i> DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>an hour</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 27</i> 19 <i>71</i> to <i>Feb 27</i> 19 <i>71</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>Feb. 27</i> 19 <i>71</i> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Reizo Tsukamoto</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <i>Reizo Tsukamoto</i> | | | | 23D. ADDRESS <i>Maryland General Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/4/71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>MT AROUAN</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 1 1971</i> | | 25B. NAME OF REGISTRAR <i>Victor E. Jabel, REG.</i> | | 25C. FUNERAL DIRECTOR <i>Marion P. Lingo</i> | | ADDRESS <i>6381 Germantown St</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2025</u> |
|---|-----------------------------|--|--|---|
| <p>P-526 <u>71 2025</u></p> <p>BIRTH NO. <u>1</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>PINKARD, ESTELLE C.</u></p> | | <p>2. DATE AND HOUR OF DEATH <u>Feb. 27 1971 11:35 P.M.</u></p> | | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Keswick</u> <u>700 W 40th St.</u></p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2711</u></p> <p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>7 WHITFIELD Rd.</u></p> | | |
| <p>5. SEX <u>F</u></p> | <p>6. RACE <u>White</u></p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH <u>2-1-'85</u></p> | <p>9. AGE (In years last birthday) <u>86</u></p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u></p> | | |
| <p>11. BIRTHPLACE (State or foreign country) <u>Virginia</u></p> | | <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p> | | |
| <p>13. FATHER'S NAME <u>James Cassey</u></p> | | <p>14. MOTHER'S MAIDEN NAME <u>Estelle Martin</u></p> | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p> | | <p>16. SOCIAL SECURITY NO. <u>220-46-0993</u></p> | | |
| <p>17. INFORMANT <u>Vergie Crouch, Keswick's Records</u></p> | | <p>ADDRESS</p> | | |
| <p>18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Massive CVA</u></p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u></p> | | |
| <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic CV disease</u></p> | | <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Years</u></p> | | |
| <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u></p> | | <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> | | |
| <p>19A. DATE OF OPERATION <u>0</u></p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No) <u>No</u></p> |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p> | | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>May 4 1962</u> to <u>Feb 27 1971</u> that (I) (we) last saw the deceased alive on <u>Feb 27 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | |
| <p>23A. SIGNATURE <u>RK Gunkley</u></p> | | <p>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p> | | <p>23B. DATE SIGNED <u>7-1-71</u></p> |
| <p>23C. PHYSICIAN'S NAME (Type) <u>RK Gunkley</u></p> | | <p>23D. ADDRESS <u>2 W University Pkwy - 21218</u></p> | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p> | | <p>24B. DATE <u>3/1/71</u></p> | | <p>24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u></p> |
| <p>24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u></p> | | <p>25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1971</u></p> | | |
| <p>25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u></p> | | <p>25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212</u></p> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| BIRTH NO. N-460 | | 71 2026 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2026 | |
| 1. NAME OF DECEASED (Type or Print) LILLIAN NAYLOR | | | | 2. DATE AND HOUR OF DEATH 2-28-71 2:00A | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21215 | | | | A. STATE Maryland | | B. COUNTY 1303 | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female | | | | 6. RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 2-6-23 | | | | 9. AGE (In years last birthday) 47 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. of Education | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Leroy Perkins | | | |
| 14. MOTHER'S MAIDEN NAME Horton | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 110 | | | |
| 16. SOCIAL SECURITY NO. 243-32-4954 | | | | 17. INFORMANT ADDRESS Miss Willamae Bell-daughter 2615 Francis St. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 404X1 | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congested Heart Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) H.C.R.D. DUE TO, OR AS A CONSEQUENCE OF: | | undetermined | |
| (C) Cardiac Arrhythmia | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Bilateral Renal Impairment | | | | | | | |
| 19A. DATE OF OPERATION none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 30, 1971 to February 28, 1971 that (I) (we) last saw the deceased alive on February 28, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Webster Sewell M.D. | | | | 23B. DATE SIGNED 3-1-71 | | 23C. PHYSICIAN'S NAME (Type) Webster Sewell, M.D. | |
| 23D. ADDRESS 2600 Liberty Heights Ave. Balto., Md. 21215 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3-4-71 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial | | 24D. LOCATION (City, town, or county) (State) Arbutus Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR W. Daley Davis Jr. | | ADDRESS 1922 Edmonson Ave. | |

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1. The first of these is the
fact that the system is not
self-sufficient, and that it
must be supplemented by other
means.

2. The second is the fact
that the system is not
flexible, and that it
must be adapted to the
needs of the situation.

3. The third is the fact
that the system is not
stable, and that it
must be maintained by
constant attention.

4. The fourth is the fact
that the system is not
secure, and that it
must be protected by
adequate measures.

5. The fifth is the fact
that the system is not
efficient, and that it
must be improved by
constant effort.

6. The sixth is the fact
that the system is not
economical, and that it
must be made to work
at the lowest possible
cost.

7. The seventh is the fact
that the system is not
simple, and that it
must be made to be
understood by all who
use it.

8. The eighth is the fact
that the system is not
complete, and that it
must be made to cover
all the needs of the
organization.

9. The ninth is the fact
that the system is not
modern, and that it
must be made to be
up-to-date with the
latest developments in
the field.

10. The tenth is the fact
that the system is not
reliable, and that it
must be made to be
dependable in all
circumstances.

11. The eleventh is the fact
that the system is not
flexible, and that it
must be made to be
adaptable to the
changing needs of the
organization.

12. The twelfth is the fact
that the system is not
secure, and that it
must be made to be
protected by adequate
measures.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2027 | | REG. NO. 71 2027 | |
|--|-------------------------|---|---|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> S-530 71 2027 </div> | | | | | | | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) LEROY SMITH | | | |
| 2. DATE AND HOUR OF DEATH 2/26/71 1:25 A.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY 1503 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Md. | | | | C. CITY OR TOWN BALTO. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 1621 Warwick Ave | | | | | | | |
| 5. SEX male | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-1-06 | 9. AGE (In years last birthday) 64 ym | If Under 1 Tr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) North Carolina | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME James Smith | | | | 14. MOTHER'S MAIDEN NAME Cora Warley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes | | | | 16. SOCIAL SECURITY NO. 23942-1100 | | 17. INFORMANT Hera Crawford | |
| ADDRESS 1623 Warwick Ave | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 43601 CAUSE OF DEATH </div> | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II | | | | (A) IMMEDIATE CAUSE CEREBRO-VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSION | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased, from 2/14/1971 to 2/26/1971 that (I) (we) last saw the deceased alive on 2/26/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE S. BASU | | | | 23B. DATE SIGNED 2/26/71 | | 23C. PHYSICIAN'S NAME (Type) S. BASU | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY Marietta Cemetery | | 24D. LOCATION (City, town, or county) (State) Fairmont, North Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | | 25C. FUNERAL DIRECTOR F. Hume | | | |
| | | | | ADDRESS 1727 N. Main St. | | | |

James Smith
Jr

239-11-1100 Lane Crawford 1832-1880
Car. 1840-1850
Part 1840-1850

1840-1850
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1840-1850
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1840-1850
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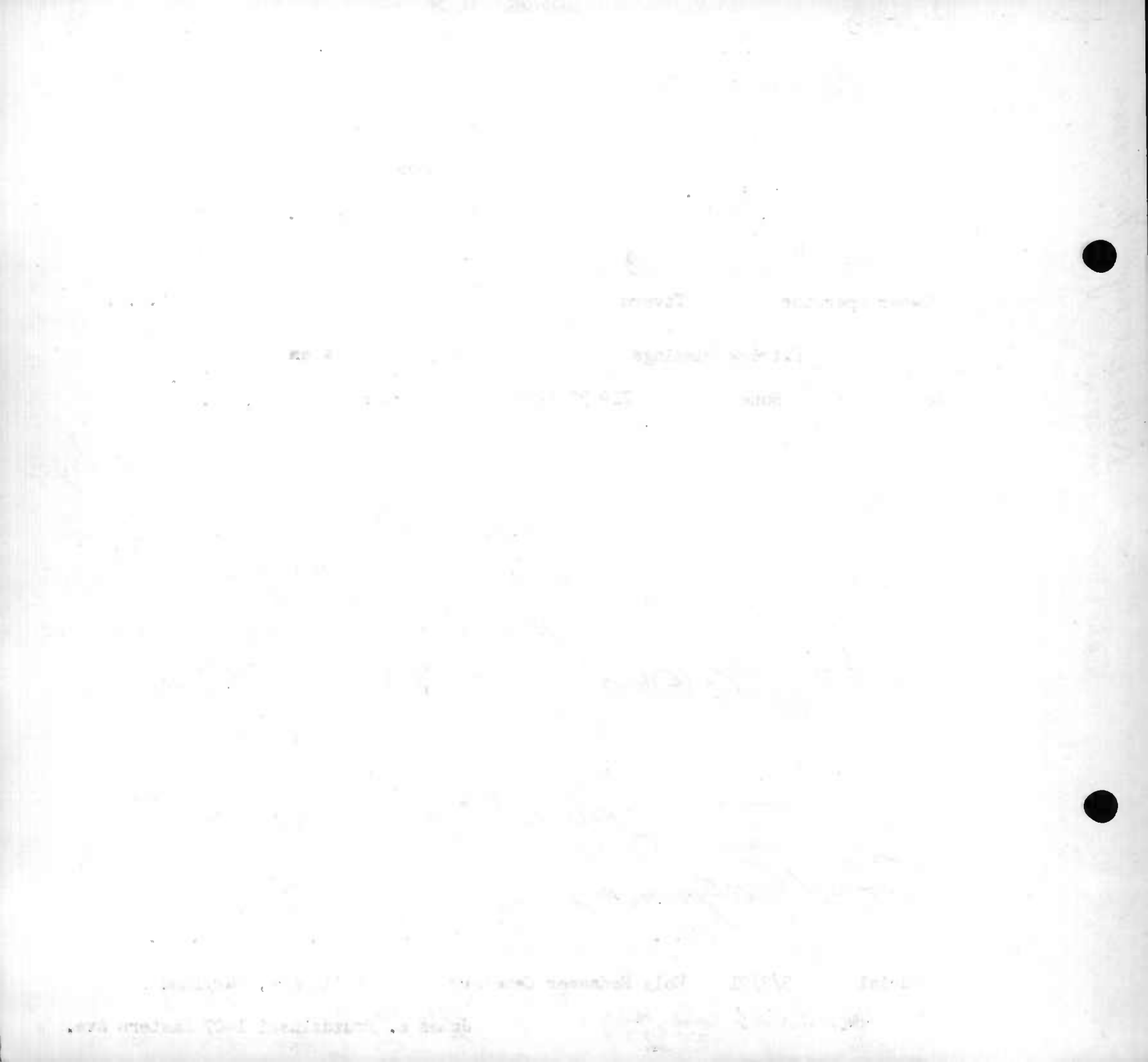
1840-1850
1840-1850
1840-1850

Released by M. Egan.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|----------------------|---|----------------------------------|---|---|--|--|
| B-500 | | 71 2028 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2028 | |
| 1. NAME OF DECEASED (Type or Print) Marlene Baum | | | | 2. DATE AND HOUR OF DEATH February 26, 1971 7:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1918 Eastfield Rd. 21222 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-29-88 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Tavern | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Patrick Cummings | | | | 14. MOTHER'S MAIDEN NAME Sarah Hagen | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219 32 1247 | | 17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury at complication which caused death.) Pneumonia | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Stroke (CVA) | | | | 6 weeks | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fractured Hip Myocardial Infarction | | | | 12 weeks | | | |
| 19A. DATE OF OPERATION 1-15-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured Hip | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? 1918 Eastfield Rd | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 11-28-70 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Slipped on rug | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 28 1970 to Feb 26 1971 , that (I) (we) last saw the deceased alive on Feb 26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Donald Saltzman M.D. | | | | 23B. DATE SIGNED 2-26-71 | | 23C. PHYSICIAN'S NAME (Type) Donald Saltzman M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/71 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Saltyk | | 25C. FUNERAL DIRECTOR James E. Brzudzinski | | ADDRESS 1407 Eastern Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|---------------------|---|--|---|---|--|------------------------------------|--|--|----------------------------------|--|
| 71 2029 CERTIFICATE OF DEATH | | | | | Registered No. 71 2029 | | | | | | |
| 1. NAME OF DECEASED (Type or Print) MARY JACOBUSKI | | | | | 2. DATE AND HOUR OF DEATH 2/27/71 8:45 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md. GEN HOSP | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21221 D. STREET ADDRESS (If rural, give location) 102 S. Stuart Ave | | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 5-7-10 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler | | | | 10B. KIND OF BUSINESS OR INDUSTRY Factory | | 11. BIRTHPLACE (State or foreign country) PA. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Michael Cherpak | | | | | 14. MOTHER'S MAIDEN NAME Mary ? | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 218 28 0943 | | 17. INFORMANT PAUL JACOBUSKI - (husband) | | ADDRESS 8700 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Acute liver failure Pocephalitis in liver | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO | | | | | | |
| | | | | | (B) DUE TO | | | | | | |
| | | | | | (C) DUE TO | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/27/71 5:45 AM to 2/27/71 that (I) (we) last saw the deceased alive on 2/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Bayani B. Elma, M.D. | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/27/71 | | | | |
| 23C. PHYSICIAN'S NAME (Type) BAYANI B. ELMA, M.D. | | | | | 23D. ADDRESS MD. GEN HOSP | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 3/3/71 | | | 24C. NAME OF CEMETERY or CREMATORY Bealir Memorial Gardens | | | 24D. LOCATION (City, town, or county) (State) Belair, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | | 25B. NAME OF REGISTRAR BRUDZINSKI | | | 25C. FUNERAL DIRECTOR BRUDZINSKI | | | ADDRESS 1407 Eastern Ave. | | |

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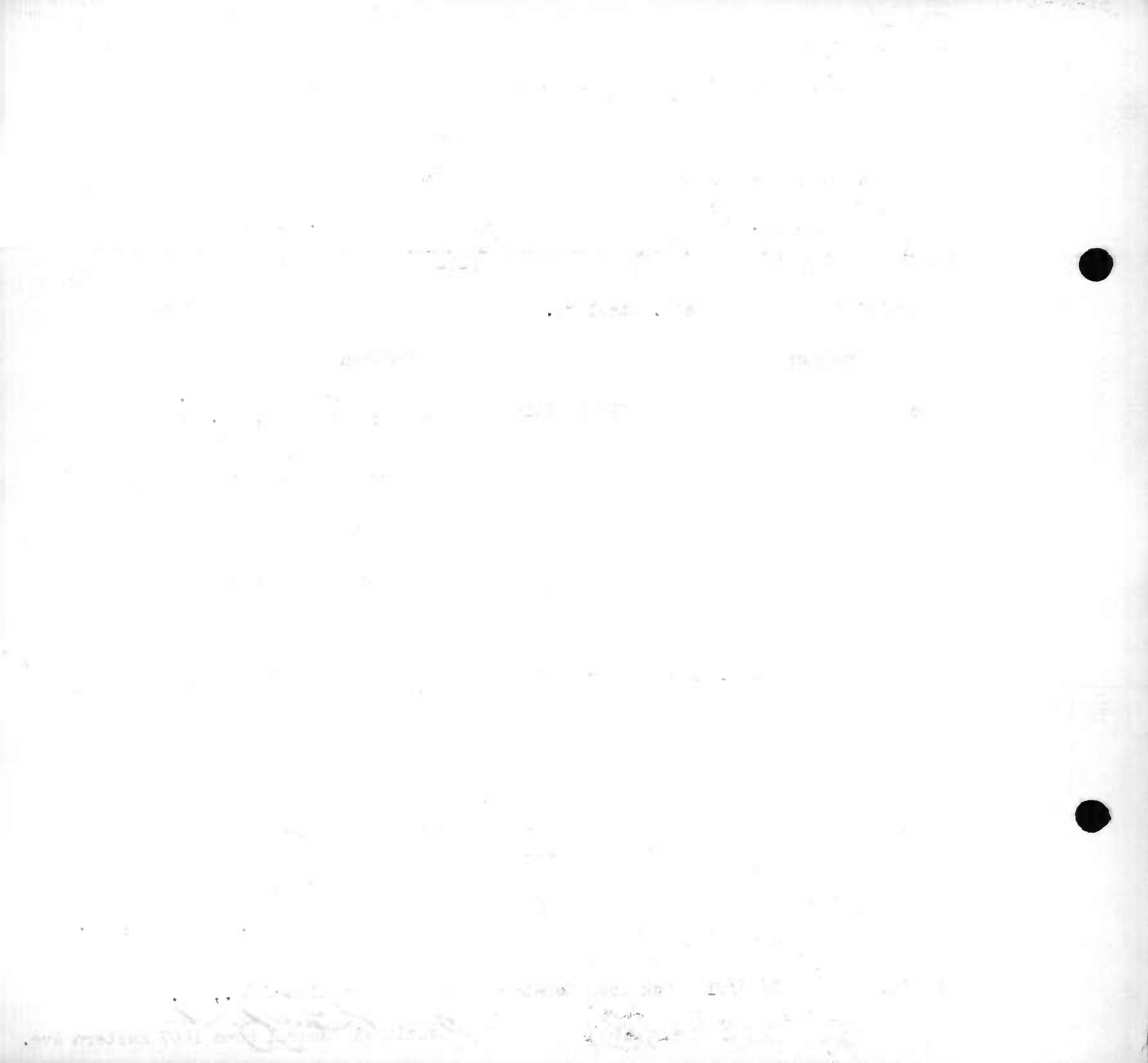
1922

1923

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

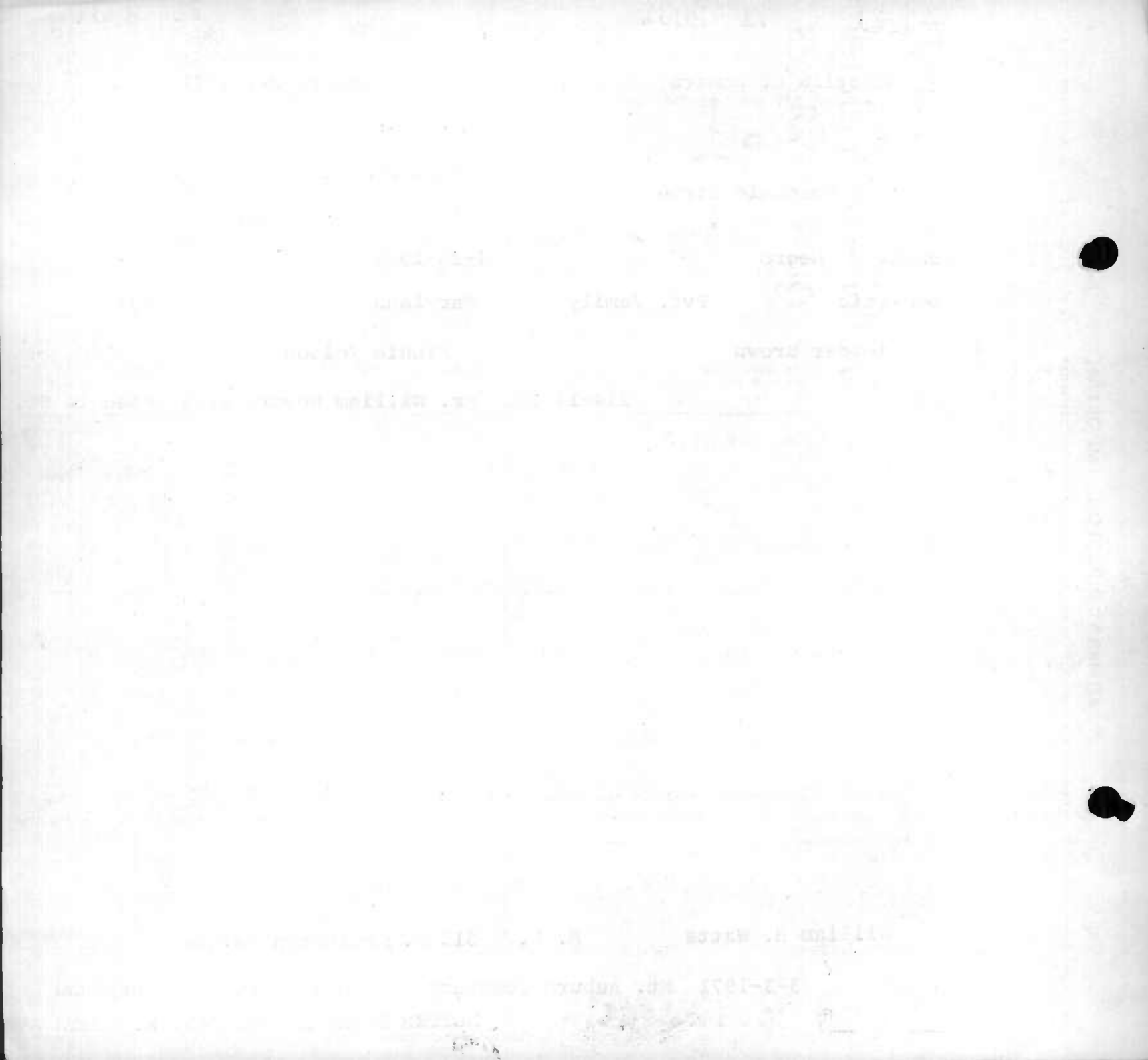
| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | 71 2030 | |
|--|--|--|--|---|--|--|--|
| BIRTH NO. 8-520 71 2030 | | | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <u>SOMOGYI, JULIO</u> | | | | 2. DATE AND HOUR OF DEATH <u>2/23/71</u> <u>1 530 P.</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Ave,</u> <u>Baltimore, Md. 21224</u> | | | | A. STATE & COUNTY <u>Maryland Baltimore</u> 5300 | | | |
| 5. SEX <u>Male</u> | | | | 6. RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u> | | 8. DATE OF BIRTH <u>11-4-80</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 9. AGE (in years last birthday) <u>90</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>212 16 0418</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hungary</u> | |
| 17. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u> | | | | ADDRESS <u>4940 Eastern Ave.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>U. T. I.</u> | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Gram Negat. Pneumonia</u> 10 days | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> | |
| 19A. DATE OF OPERATION <u>2/23/71</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>U. T. I.</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>C. V. A. - ASCUP</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>3 months</u> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>2/23/71</u> | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>3 months</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/25/70</u> 19 <u>70</u> to <u>2/23/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>2/23/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>M. A. Z. Z. I.</u> | | | | 23B. DATE SIGNED <u>2/23/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>M. A. Z. Z. I.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. DATE <u>2/26/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1971</u> | | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Bruzdzinski Funeral Home</u> | |
| 24D. LOCATION <u>Baltimore Co., Md.</u> | | | | 25D. ADDRESS <u>1407 Eastern Ave.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2031 | | REG. NO. 71 2031 | |
|--|-------------------------|---|---|---|--|---|--|
| BIRTH NO. <u>4-630</u> | | | | 71 2031 CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Monzella C. Howard | | | | 2. DATE AND HOUR OF DEATH February 26, 1971 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1606 Rosedale Street | | | | A. STATE Maryland | | B. COUNTY 1607 | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 1606 Rosedale Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-25-1909 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | 10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Fielder Brown | | | | 14. MOTHER'S MAIDEN NAME Minnie Tolson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-14-2559 | | 17. INFORMANT ADDRESS Mr. William Howard 1606 Rosedale St. | | | |
| 18. 162.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Emphysema of lungs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 mo | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-21 1969 to 2-26 1971 , that (I) (we) last saw the deceased alive on 2-15 1971 and that in (my) last apian death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE William H. Watts | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-1-71 | |
| 23C. PHYSICIAN'S NAME (Type) William H. Watts | | | | 23D. ADDRESS M. D. 515 N. Arlington Avenue | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-1971 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Talbot | | 25C. FUNERAL DIRECTOR ADDRESS NOTTER FUNERAL HOME 3035 W. NORTH AVE | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2032 | |
|--|-------------------------|---|---|--|--|
| BIRTH NO. 4-536 71 2032 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Waverly Matthew Hendricks | | | 2. DATE AND HOUR OF DEATH February 27, 1971 2³⁰ P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2927 Gwynns Falls Parkway | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1547 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2927 Gwynns Falls Pkwy. | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-19-1921 | 9. AGE (In years last birthday) 49 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10B. KIND OF BUSINESS OR INDUSTRY Public School | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME William Hendricks | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 229-20-6917 | | 17. INFORMANT Rev. Haywood Hendricks |
| 18. 1/35501 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Hepatoma and metastases | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatoma and metastases (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles I. Siegal | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) Charles I. Siegal M. D. |
| 23D. ADDRESS 11 E. Chase Street | | | 23E. FURNERAL DIRECTOR 200 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-1971 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION Baltimore Co. Maryland | | 24E. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | | |
| 24F. NAME OF REGISTRAR Robert E. Taylor | | 24G. ADDRESS 200 | | | |
| 24H. FUNERAL HOME 200 | | | | | |

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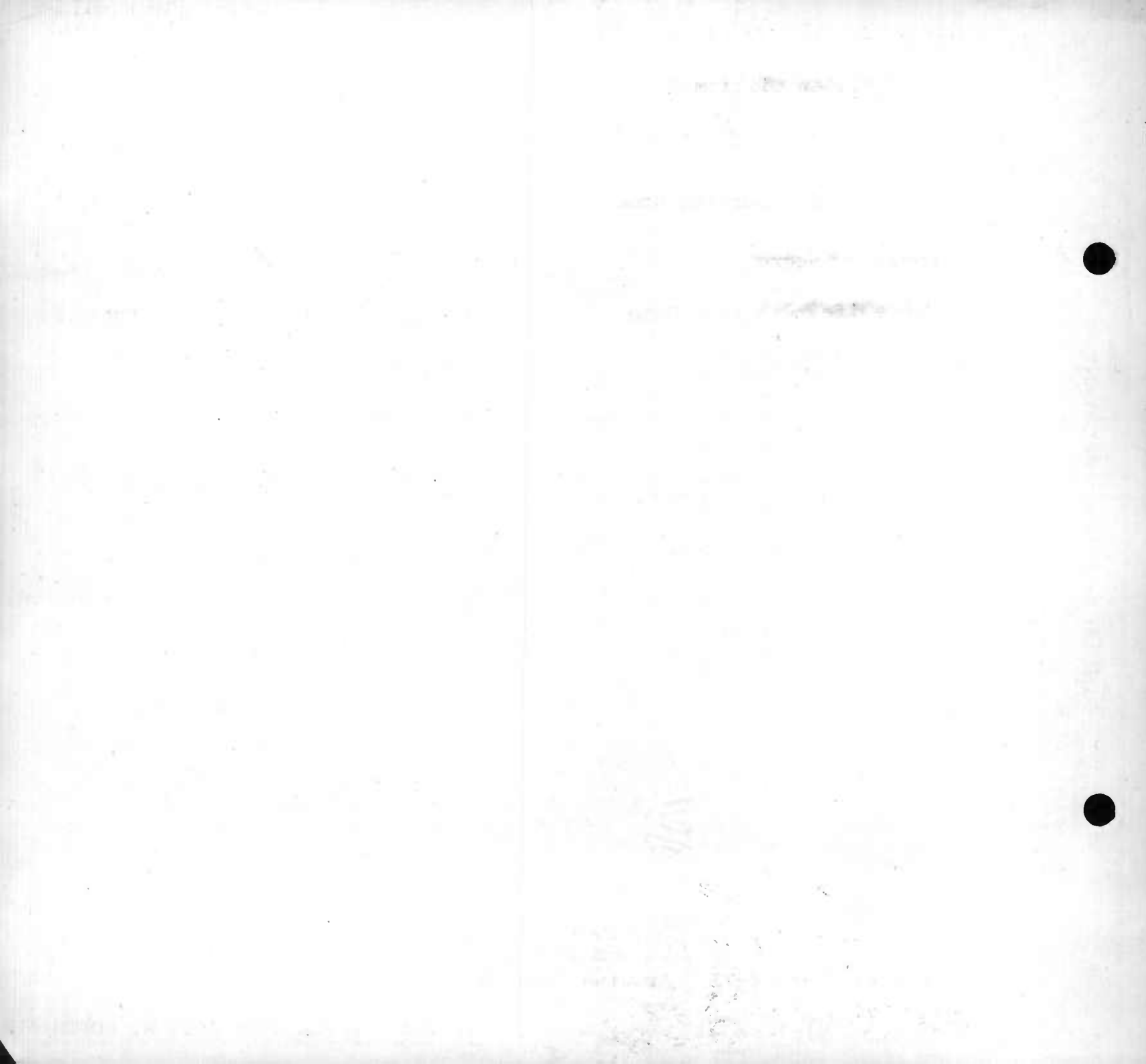
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | Baltimore City Health Department | | REG. NO. | |
|---|-------------------------|---|-----------------------------------|---|---|
| G-450 | | 71 2033 | | 71 2033 | |
| 1. NAME OF DECEASED (Type or Print) Aileen Gilliam | | 2. DATE AND HOUR OF DEATH 2-27-71 6:38 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Nursing Home | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 3601 Eversley Street | | | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 2-7-30 | 9. AGE (In years lost birthday) 41 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) Wardensville, West Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Melvin Grandison | | 14. MOTHER'S MAIDEN NAME Payne, Thelma | | ADDRESS Leonard Gilliam - 806 Wildwood Pkwy | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Leonard Gilliam | |
| 18. 3-7-71 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: coronary artery | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) portal hypertension DUE TO, OR AS A CONSEQUENCE OF: | | years | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/25 19 71 to 2/27 19 71 , that (I) (we) last saw the deceased alive on 2/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE al Macht | | | | 23B. DATE SIGNED 2/28/71 | |
| 23C. PHYSICIAN'S NAME (Type) al Macht MD | | 23D. ADDRESS 2 E Pearl St Baltimore, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-71 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME | |
| ADDRESS 3035 W. NORTH AVE | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 2034 | | | |
|--|--|--|--|--|--|--|--|
| BIRTH NO. <u>A-426</u> <u>71</u> <u>2034</u> | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| <u>ALCORN, WILLIAM RENT</u> | | | | <u>2 22 71</u> <u>10.50 P. M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE <u>MD</u> B. COUNTY <u>4606 E LAWN PARK RD 21229</u> | | | |
| <u>UNIVERSITY HOSPITAL</u> | | | | C. CITY OR TOWN <u>BALTO.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| <u>38</u> | | | | E. STREET AND NUMBER <u>4606 LAWN PARK RD.</u> <u>2864</u> | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2 11 71</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | | 11. BIRTHPLACE (State or foreign country) | |
| <u>NONE</u> | | <u>NONE</u> | | <u>11</u> | | <u>Maryland</u> | |
| 13. FATHER'S NAME <u>WILLIAM FALCORN JR.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Linda Morris</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Wm. E. Alcorn Jr.</u> | |
| 18. <u>74616 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> | | | |
| ANTECEDENT CAUSES | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | <u>CONGENITAL HEART DISEASE</u> | | | |
| (B) _____ | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION <u>3 2 22 71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>drainage</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | 21G. WHERE DID INJURY OCCUR? | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2 20</u> 19 <u>71</u> to <u>2 22</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>2 22</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Gopala Krishnan</u> | | | | 23B. DATE SIGNED <u>2 22 71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>DR GOPALA KRISHNAN</u> | |
| 23D. ADDRESS <u>UNIVERSITY HOSPITAL</u> | | | | 23E. DATE SIGNED | | 23F. PHYSICIAN'S NAME (Type) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-26-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>PROTHAWN GARDEN</u> | | 24D. LOCATION (City, town, or county) (State) <u>ELLICOTT CITY, MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u> | | 25C. FUNERAL DIRECTOR <u>Registration Block</u> | | 25D. ADDRESS <u>ELLICOTT CITY, MD</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. |
|---|---------|---|--|--|
| 71 2035 | | 71 2035 | | 71 2035 |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| BLANCHE ALVERTA LUTZ | | Feb. 24, 1971 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 4217 Conneticut Avenue | | A. STATE Md | | |
| | | B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER | | F. INSIDE CITY LIMITS? | | |
| 4217 Conneticut Ave, | | 21229 | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) |
| Female | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | July 23, 1913 | 57 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| At Home | | None | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| William H. Crimes | | Rose Ellen Sullivan | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | |
| No | | None | Charles M. Dorsey, 4217 Conneticut Ave. | |
| 18. 410.9 I | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | Acute Myocardial Infarction | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 0 | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | 2/24/71 | |
| 22. I certify that (I) (this hospital) attended the deceased from 1950 to 1971 | | that (I) (we) lost saw the deceased alive on 2/24 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | |
| Robert A. Hallen MD | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| Burial | | 2-27-1971 | Crest Lawn | Ellicott City, Md |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR |
| MAR 1, 1971 | | R. G. E. Taylor, Jr. | | Slack, Ellicott City, Md |



Handwritten text, possibly a signature or name, located in the upper left quadrant.

Handwritten text, possibly a signature or name, located in the lower left quadrant.

Handwritten text, possibly a signature or name, located in the lower right quadrant.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2036 | |
|--|-------------------------|--|---|--|--|
| BIRTH NO. <u>5-530</u> | | 71 2036 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>SMITH, GLADYS MAE</u> | | | 2. DATE AND HOUR OF DEATH <u>FEBRUARY 21, 1971</u> <u>5:00 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>40 ST. AGNES HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>HOWARD</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>40 ST. AGNES HOSPITAL</u> | | | C. CITY OR TOWN <u>ELLICOTT CITY</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER <u>4449 CENTENNIAL LANE 21043</u> | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>06 24 08</u> | 9. AGE (In years last birthday) <u>62</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>JAMES KKK LEDFORD</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>WILLIE MAE MC CLURE</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | |
| 16. SOCIAL SECURITY NO. <u>220-208758</u> | | | 17. INFORMANT <u>WILKENS AVE BALTO MD. 21229</u> <u>ST AGNES HOSPITAL RECORDS CATON &</u> | | |
| 18. <u>398X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRAIN EMBOLISM, Infart</u> Left occipital Lobe | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>Pneumatic heart Disease</u> 40 years. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from <u>FEBRUARY 05</u> 19 <u>71</u> to <u>FEBRUARY 21</u> 19 <u>71</u> that (X) (we) last saw the deceased alive on <u>FEBRUARY 21</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | 23B. DATE SIGNED <u>2 22 71</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>CARLOS V. ROZENBOM</u> | | | 23D. ADDRESS <u>St. AGNES HOSP WILKENS & CATON</u> <u>BALTO MD 21229</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2-26-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Taylorville</u> | |
| 24D. LOCATION <u>Taylorville</u> | | 24E. LOCATION <u>Taylorville</u> | | 24F. LOCATION <u>Taylorville</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Hyndman Block</u> | |
| 25D. ADDRESS <u>Ellicott City</u> | | | | | |

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|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2037 | |
|---|----------------------------|---|--|---|---|
| BIRTH NO. M-600 | | 71 2037 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MOHR, ANDREW | | | 2. DATE AND HOUR OF DEATH 2/25/71 205/PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY ALLEGANY | | | 5. CITY OR TOWN Balt D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 6. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Good Samaritan Hospital | | | E. STREET AND NUMBER 5N Exeter St 302 | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/26/96 | 9. AGE (In years last birthday) 74 yrs | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 486X1 CARDIO-RESPIRATORY ARREST ANTECEDENT CAUSES GRAM-NEGATIVE SEPSIS PNEUMONIA + EMPYEMA | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO RELATIVES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/18/71 19 71 to 2/25/71 19 71 that (I) (we) last saw the deceased alive on 2/25/71 2 PM 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rein Saral M.D. | | | | 23B. DATE SIGNED 2/25/71 | |
| 23C. PHYSICIAN'S NAME (Type) REIN SARAL M.D. | | | | 23D. ADDITIONAL INFORMATION ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3-1-71 | | 24C. NAME OF CEMETERY or CREMATORIUM JOHNS HOPKINS MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1, 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. ADDRESS MORTUARY SERVICE - BCD | |

P-100

71 2038

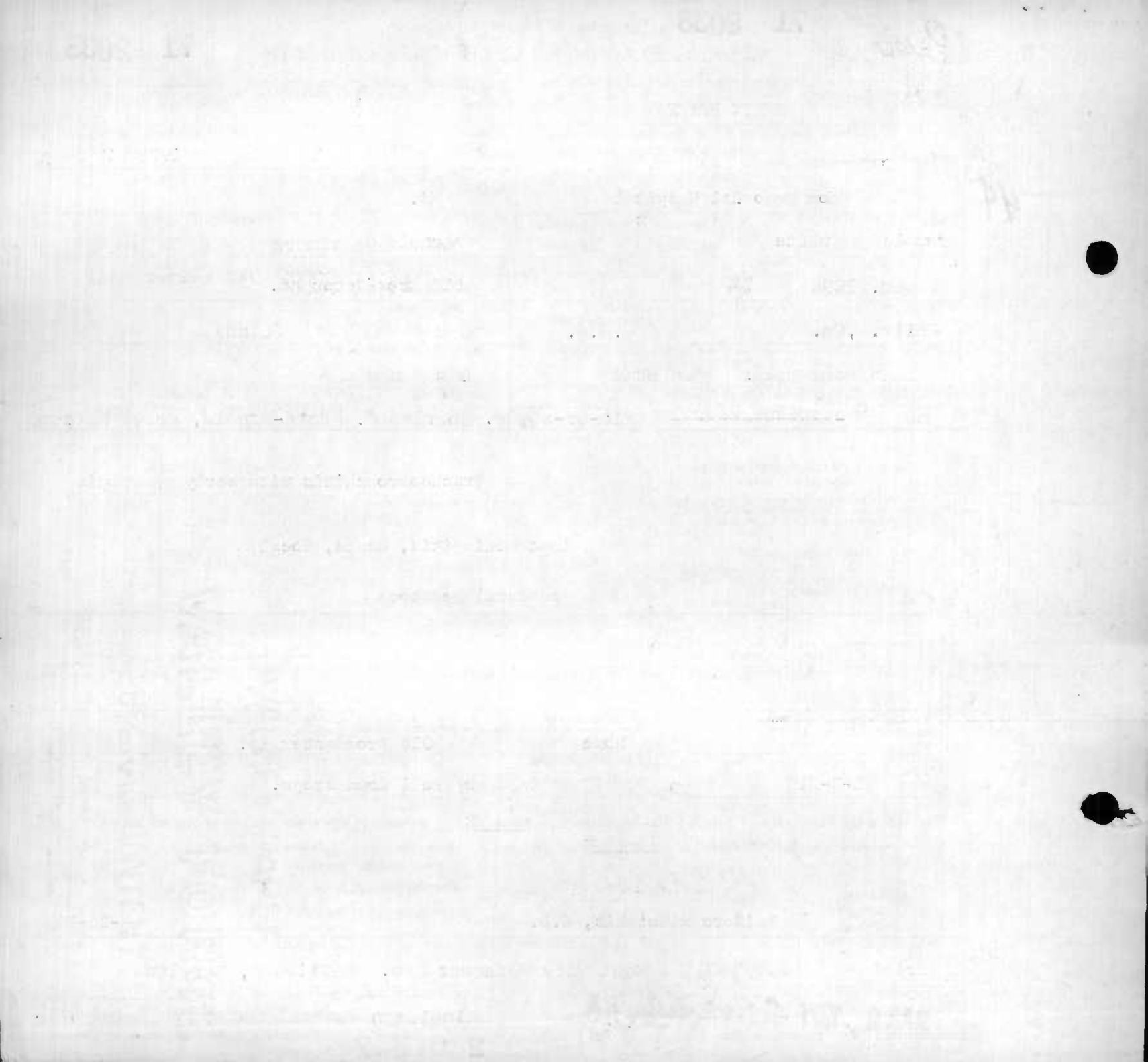
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2038

BIRTH NO.

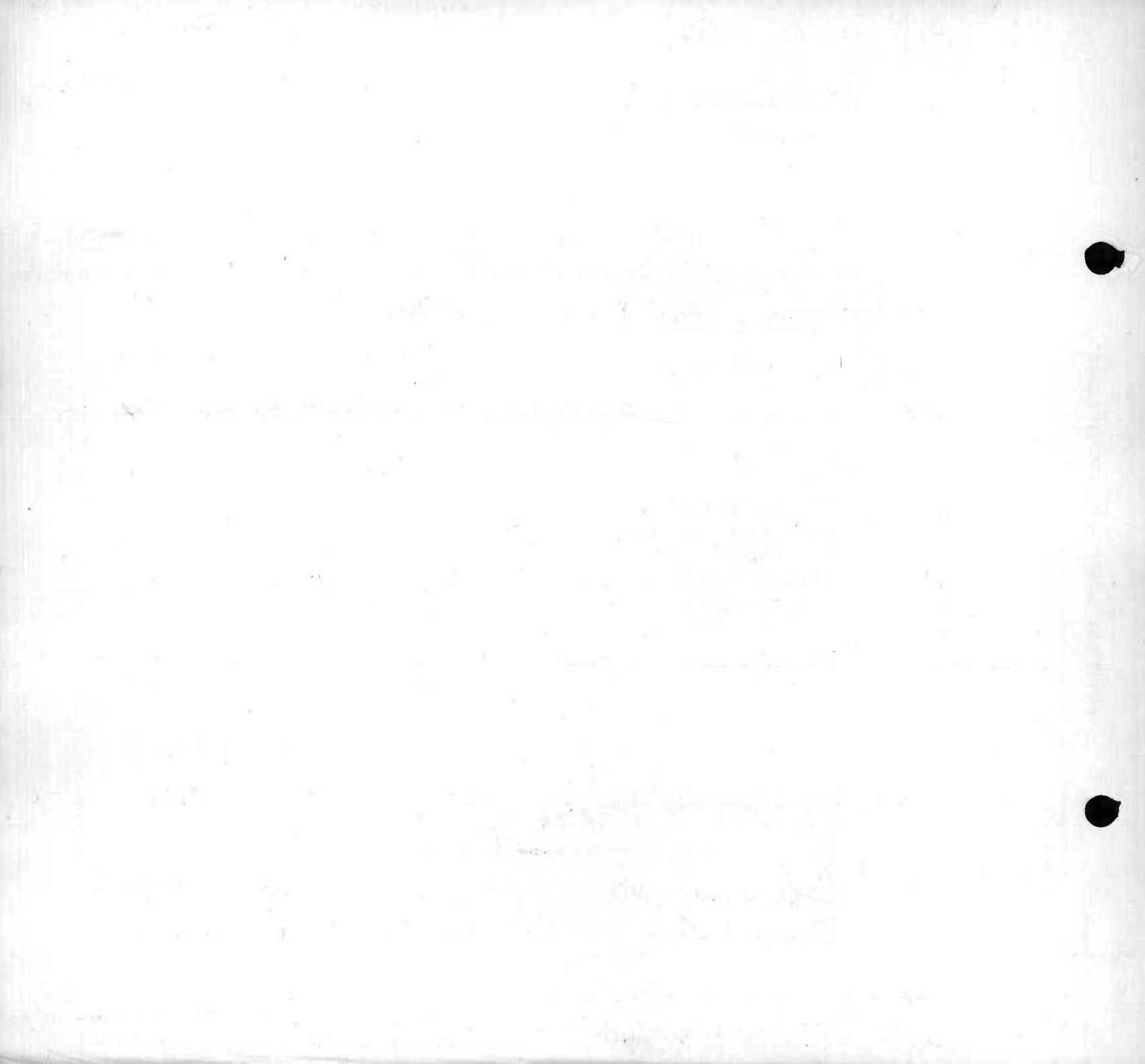
| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) MAMIE PFAFF | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 25 1971 12:30 p.m. | |
| 6. SEX female | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE white | | 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY | |
| 9. DATE OF BIRTH 29 Aug. 1894 | | 10. AGE (In years lost birth day) 76 | |
| 11. BIRTHPLACE (State or foreign country) Phila., Pa. | | 12. CITIZEN OF U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker | | 14B. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 218-09-8300 | |
| 13. FATHER'S NAME *UNKNOWN (Lynd) | | 15. MOTHER'S MAIDEN NAME unknown | |
| 18. INFORMANT Charles F. Pfaff-Arnold, Maryland(son) | | ADDRESS | |
| 19. CAUSE OF DEATH E880X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Tracheobronchitis with early pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. leptomeningitis, acute, focal subdural hematoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 328 Broadwater Rd. 52-00 | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) 2-2-71 | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Fell down steps. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. DATE SIGNED 2-26-71 EXAMINER'S NAME (Type) | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2, 1971 | | 25B. NAME OF REGISTRAR Isidore E. Mihalakis, M.D. | |
| 25C. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

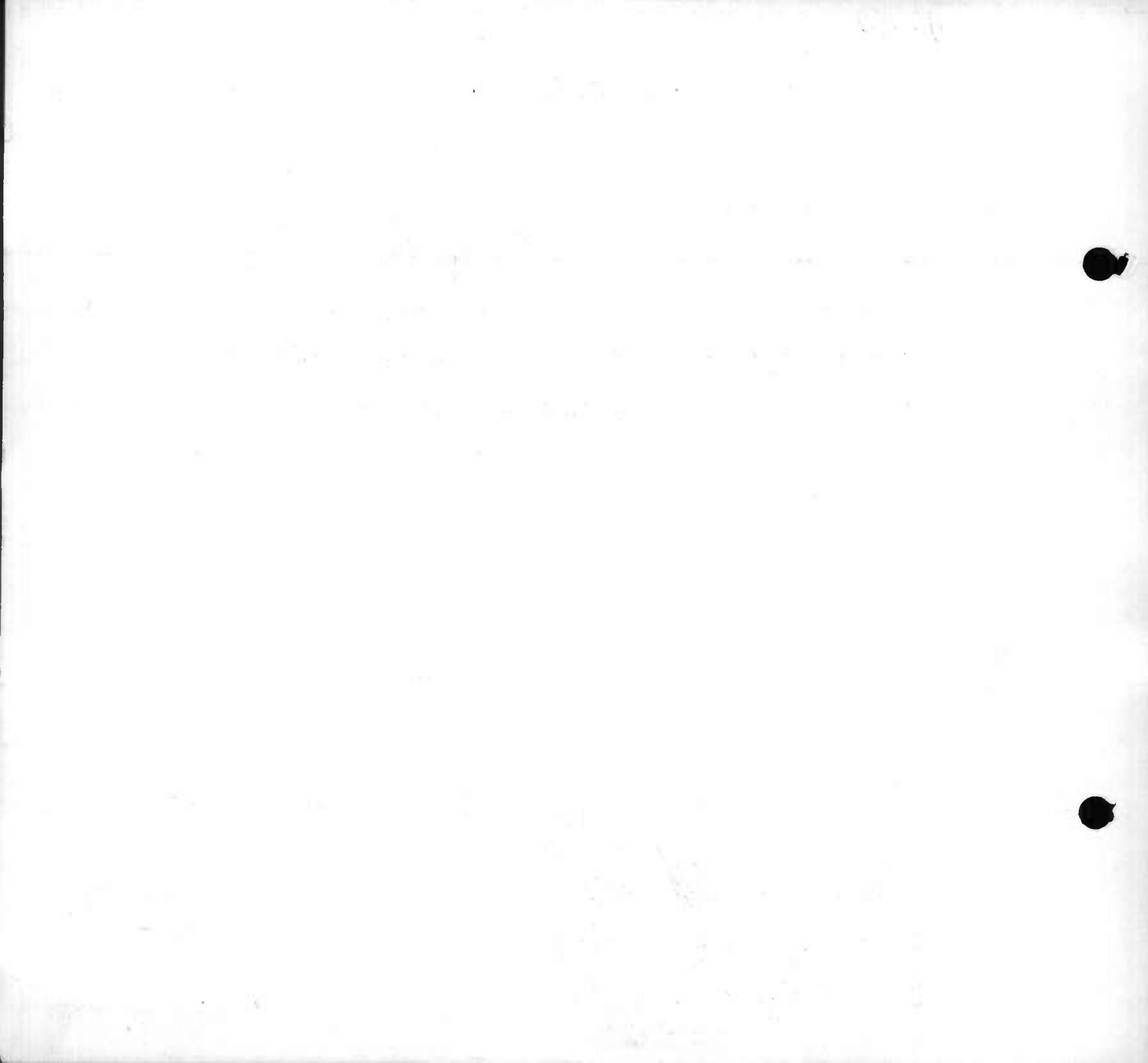
| | | | |
|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2039 | |
| BIRTH NO. 4-220 71 2039 | | 1. NAME OF DECEASED (Type or Print) Bernard F. Hughes | |
| 2. DATE AND HOUR OF DEATH 2/23/71 1:40 P M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Johns Hopkins Hospital | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Prince Georges | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital | |
| C. CITY OR TOWN Laurel, Md. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 401 Carroll Ave | | 6. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 8-13-97 | | 9. AGE (In years last birthday) 73 | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. SURVEYOR | | 10B. KIND OF BUSINESS OR INDUSTRY W.S.S.C. | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME EDWIN HUGHES | | 14. MOTHER'S MAIDEN NAME CLARA ANSTINE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A | | 16. SOCIAL SECURITY NO. 215-3P-310P | |
| 17. INFORMANT MRS. MARGARET HUGHES | | ADDRESS #12 SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PROB. PULM EMBOLUS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. POST-OP PANCREATIC CAECINOMA | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/27 19 71 to 2/23 19 71 , that (I) (we) last saw the deceased alive on 2/23 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE David Leberer, MD | | 23B. DATE SIGNED 2/23/71 | |
| 23C. PHYSICIAN'S NAME (Type) DAVID LEBERER | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | | 24B. DATE 2/26/71 | |
| 24C. NAME OF CEMETERY or CREMATORY FORT LINCOLN CREMATORY | | 24D. LOCATION (City, town, or county) (State) PRINCE GEORGES Co. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR LAUREL FUNERAL HOME INC. | | ADDRESS 550 WASH. BLVD LAUREL, MD 20610 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

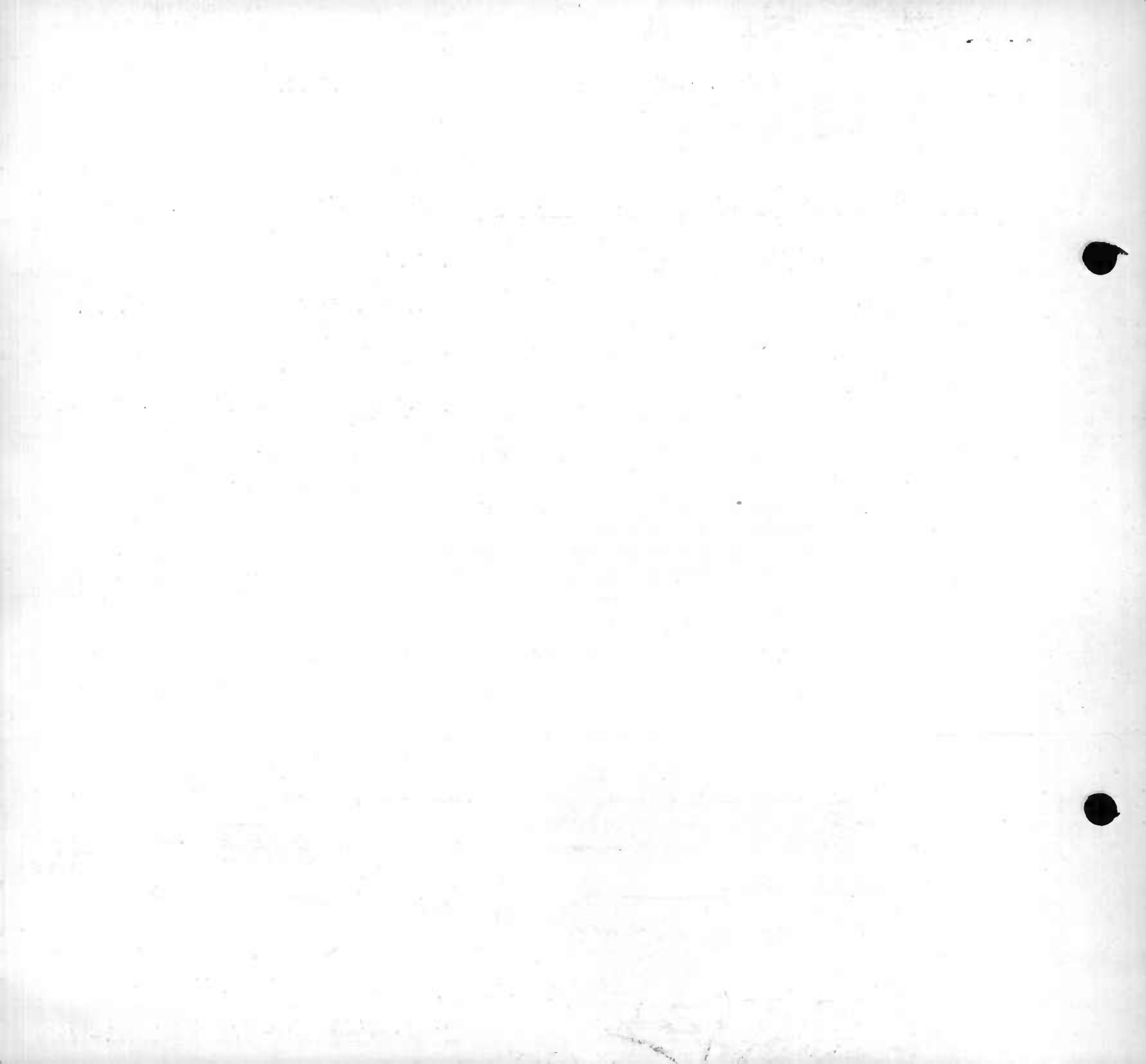
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. | |
|---|---------|--|--|---|--|--|--|
| W-450 | | 71 2040 | | X | | 71 2040 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| STANLEY J. WHELAN Jr. | | | | FEB 27 1971 10 ³⁰ P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| USPHS HOSPITAL | | | | MD. (Baltimore 53-00) | | | |
| WYMAN PK DRIVE & 31ST ST. | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | ELLICOTT CITY | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 4850 BONNIE VIEW CT. | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | |
| M | W | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9/23/48 | | 22 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | | | MD. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| STANLEY WHELAN, SR. | | | | RUTH RENDLE Peddle | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | 214 54 1124 | | RECORDS USPHS HOSP. BALTO. | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (R) FRONTAL ASTROCYTOMA | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/28 1969 to 2/27 1971 that (I) (we) last saw the deceased alive on 2/27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Irwin Zarembok MD | | | | 2/27/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| IRWIN ZAREMBOK, SURG(R) | | | | USPHS HOSP. BALTO. MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 3/3/71 | | Cedar Hill Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| MAR 2 1971 | | Robert E. Gaby, M.D. | | Mc Cully Funeral Home Balto Md. | | 21225 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2041 | |
|---|---|---|--|---|---|
| BIRTH NO. M-250 71 2041 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Mattie B. Machen | | | 2. DATE AND HOUR OF DEATH Feb. 24, 1971 8 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 9-05 | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 601 Montpelier Street | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 10, 1875 | 9. AGE (In years last birthday) 95 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home M'ker | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Petersburg, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Jesse Parker | | |
| 14. MOTHER'S MAIDEN NAME Isabella | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. - | | | 17. INFORMANT Mrs. Alice Jackson - 601 Montpelier St. | | |
| 18. 1538 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Carcinoma of colon ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. with generalized metastasis | | | CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2/23 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 23 19 49 to 2/23 19 71 . that (I) (we) last saw the deceased alive on 2/23 19 71 and that in (my) (our) opinion death occurred on the date Dr. E. E. Look's postmortem seen by me on and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | 23B. DATE SIGNED 2/23/71 | | 23C. PHYSICIAN'S NAME (Type) MARION FRIEDMAN, M.D. | |
| 23D. ADDRESS 5211 Harford Rd | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 2-27-71 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2, 1971 | | 25B. NAME OF REGISTRAR John C. Miller | | 25C. FUNERAL DIRECTOR Inc-6415 Belair Rd. -21206 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2042 | |
|--|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. 71 2042 | |
| BIRTH NO. P-200 | | 71 2042 | | | |
| 1. NAME OF DECEASED (Type or Print) Miss Agnes Posko | | | 2. DATE AND HOUR OF DEATH Feb 25, 1971 11:20 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE: Md. B. COUNTY: Balt. City | | |
| 5. SEX: FEMALE | | | 6. RACE: WHITE | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH: 12/4/03 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY Own | | |
| 13. FATHER'S NAME: Andrew Posko | | | 14. MOTHER'S MAIDEN NAME: Julianna Piskor | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO.: 214-30-2745A | | |
| 17. INFORMANT: Mrs. Irene Nickel, 8041 Bank St. | | | ADDRESS | | |
| 18. CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE: acute pulmonary infection 1 1/2 hr DUE TO, OR AS A CONSEQUENCE OF: (B) Bilateral ovarian carcinoma - Metastasis 2 weeks DUE TO, OR AS A CONSEQUENCE OF: (C) cerebral metastasis, probable 3 days | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION: Feb 13, 1971 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: bilateral ovarian carcinoma | | 20A. AUTOPSY? (Yes or No): No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.): | | 21E. INJURY OCCURRED: While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3 weeks 19 to 2/25/71 that (I) last saw the deceased alive on 2/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE: John H. Hebb | | | | 23B. DATE SIGNED: 2/25/71 | |
| 23C. PHYSICIAN'S NAME (Type): JOHN H. HEBB | | | | 23D. ADDRESS: 8413 Loch Raven Blvd Bmd | |
| 24A. BURIAL - CREMATION, REMOVAL (Specify): Burial | | 24B. DATE: 3/1/71 | | 24C. NAME of CEMETERY or CREMATORY: St. Stanislaus | |
| 24D. LOCATION: Baltimore, Maryland | | 25A. DATE RECD BY: M. F. Sadowski | | | |
| 25C. FUNERAL DIRECTOR: M. F. SADOWSKI & SONS, 1808 EASTERN AVE | | | | | |



| | | | |
|--|--|--|--|
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM RAY HALL | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) OR INSTITUTION 1723 St. Paul St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 25 1971 5:50 pm M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY | |
| 9. DATE OF BIRTH MARCH 10, 1929 | | 10. AGE (In years last birthday) 41 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DAVID RAY HALL | | 14. MOTHER'S MAIDEN NAME VIVIAN M. MC CRODY | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER | | 14B. KIND OF BUSINESS OR INDUSTRY PAINTING | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES KOREA | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT HARRISON FUNERAL HOME | | ADDRESS LEXINGTON VA | |
| 18. CAUSE OF DEATH Active pulmonary tuberculosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 2-26-81 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-2-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Carmel | | 24D. LOCATION (City, town, or county) (State) STATES TOWN VA. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR Wm. Cook-Beckwith-Townson, Inc. | | ADDRESS TOWSON MD | |

X

DAVID RAY HALL

V. A. M. O'Leary

DAVID RAY HALL

March 10, 1957

DAVID RAY HALL

U.S.A.

DAVID RAY HALL

DAVID RAY HALL

DAVID RAY HALL

DAVID RAY HALL

DAVID RAY HALL

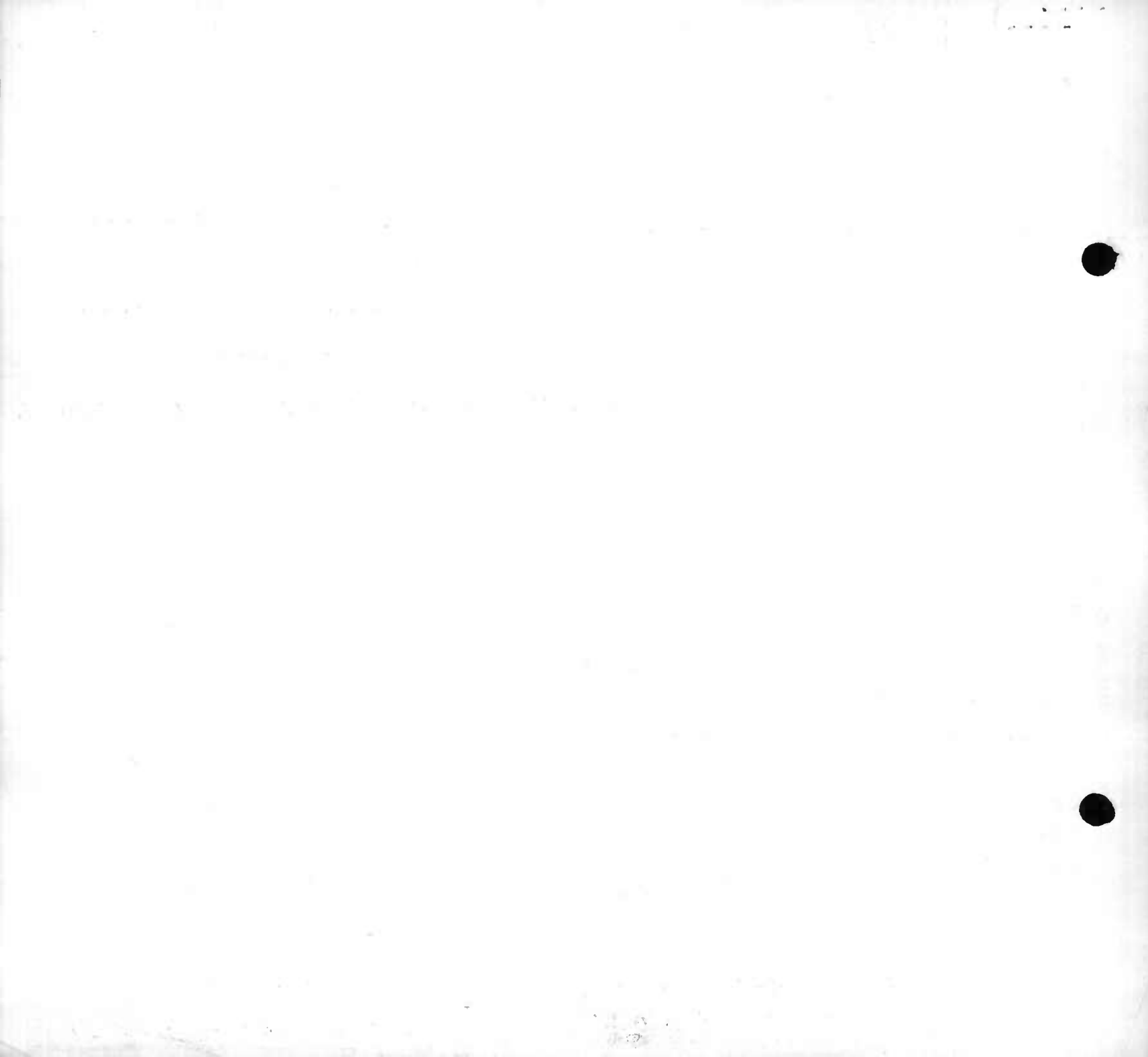
DAVID RAY HALL

DAVID RAY HALL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

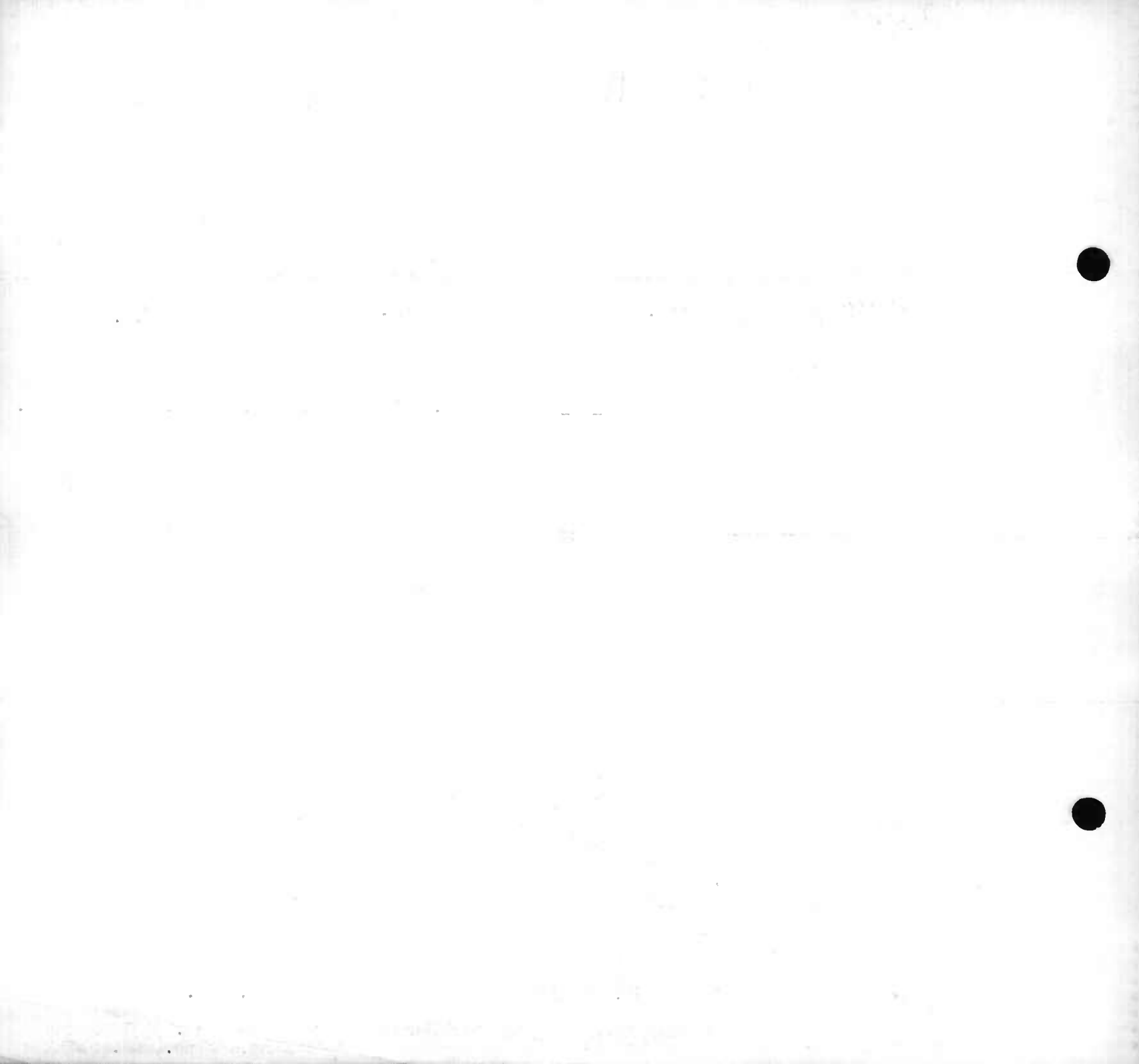
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. |
|---|-------------------------|---|------------------------------------|--|
| R-320 71 2044 | | 71 2044 | | |
| 1. NAME OF DECEASED (Type or Print) RIETSCHY JOSEPHINE R. | | 2. DATE AND HOUR OF DEATH 2 - 25 - 71 3:15 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | E. STREET AND NUMBER 2156 REDTHORN ROAD # 20 | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/28/31 | 9. AGE (In years last birthday) 39 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | | 11. BIRTHPLACE (State or foreign country) Columbia, B.C. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles Hammond | | |
| 14. MOTHER'S MAIDEN NAME Marguerite Bartini | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 579-40-2544 | | 17. INFORMANT Frederick Robert Rietschy -2156 Redthorn Rd. | | |
| 18. 43091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| (A) IMMEDIATE CAUSE SUBARAGNOID HEMORRAGE DUE TO, OR AS A CONSEQUENCE OF: | | DAYS | | |
| (B) A-V MALFORMATION OF BRAIN DUE TO, OR AS A CONSEQUENCE OF: | | YEARS | | |
| (C) _____ | | _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 12/18/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 2/17 19 71 to 2/25 19 71 that (I) (we) last saw the deceased alive on 2/25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Franklin Weinstein M.D. | | 23B. DATE SIGNED 2/25/71 | | 23C. PHYSICIAN'S NAME (Type) FRANKLIN WEINSTEIN |
| 23D. ADDRESS SINAI HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 3-1-71 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, R.D. | | 25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road-21206 |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT 71 2045 71 2045 | | | | REG. NO. 2045 | |
|--|---------------------|--|--|---|--|
| B-422 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Michael Blackowicz | | | | 2. DATE AND HOUR OF DEATH 2/24/71 18 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Montebello State Hosp | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY Balto | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Montebello State Hosp | | | | C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 609 N Lakewood Ave | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/2/08 | 9. AGE (In years last birthday) 62 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist tool room attendant | | 10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | 11. BIRTHPLACE (State or foreign country) Balto. | |
| 13. FATHER'S NAME Joseph Blachowicz | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 213-10-3529 | |
| 17. INFORMANT Mrs. Helen Blachowicz | | | | ADDRESS 609 N. Lakewood Ave. | |
| 18. 34801 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) AMYOTROPHIC LATERAL SCLEROSIS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Aspiration pneumonia | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/> Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/10/71 19__ to 2/24/71 19__ that (I/we) lost saw the deceased alive on 2/24/71 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stuart, M.D. | | | | 23B. DATE SIGNED 2/24/71 | |
| 23C. PHYSICIAN'S NAME (Type) Franklin Stuart | | | | 23D. ADDRESS Montebello State Hosp | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 2/27/71 | | 24C. NAME of CEMETERY or CREMATORY St. Stanislaus | |
| 24D. LOCATION (City, town, or county) (State) Balto., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

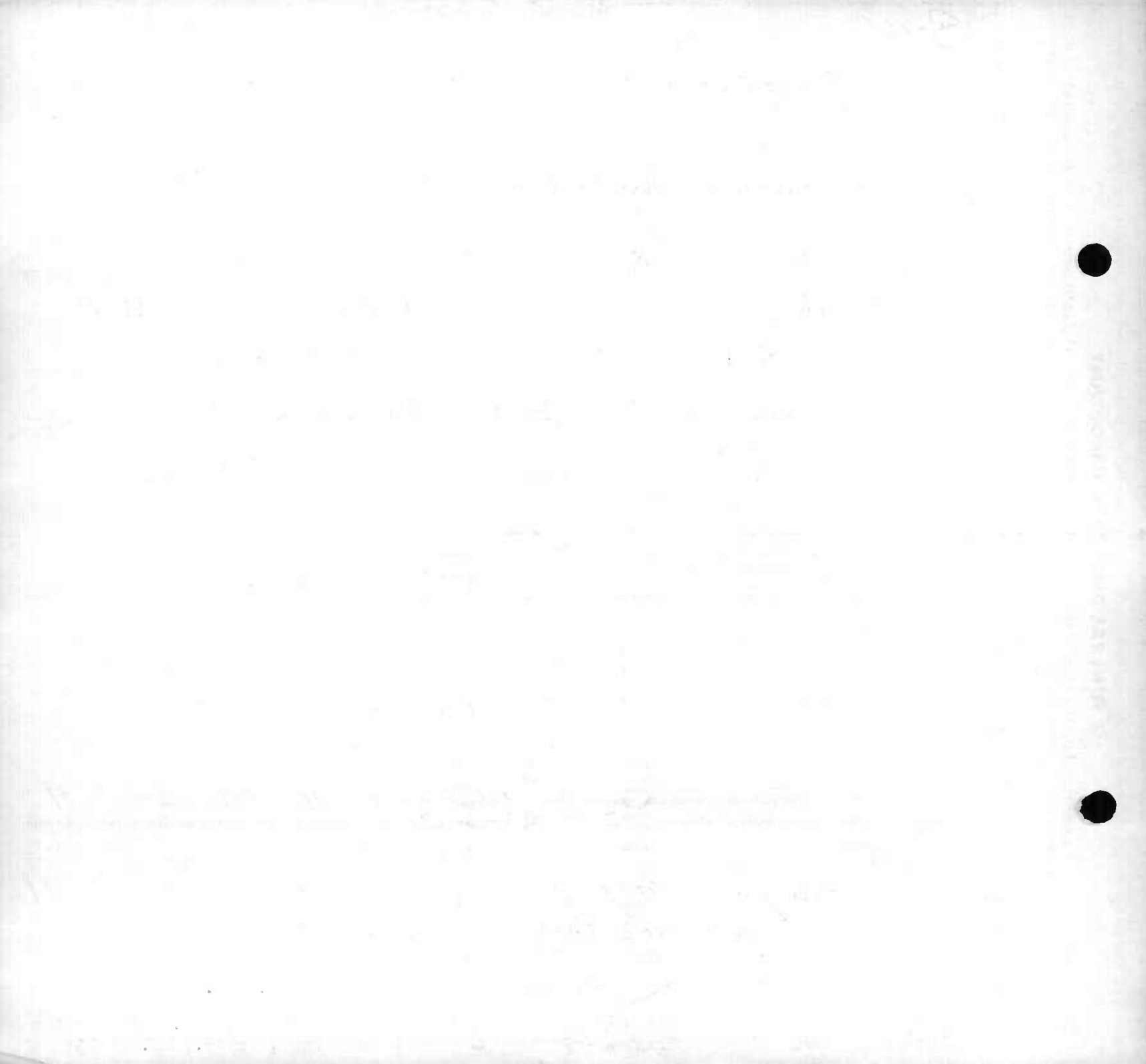
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2046 | 71 2046 |
|--|--|---|--|--|---|
| BIRTH NO. | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) ELLEN M. POSEY | | | 2. DATE AND HOUR OF DEATH 2-22-71 7:00 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD MARYLAND GENERAL HOSP | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSP | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 9-20-06 | | 9. AGE (in years last birthday) 64 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212-01-9580 | | 17. INFORMANT HUSBAND JAMES A. POSEY |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) RENAL FAILURE | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RENAL FAILURE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MYXEDEMA | | | (B) DUE TO, OR AS A CONSEQUENCE OF: MYXEDEMA | | ? |
| (C) _____ | | | _____ | | _____ |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cardiomyopathy | | | _____ | | _____ |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-10-71 19 71 to 2-22 19 71 that (I) (we) last saw the deceased alive on 2-22 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William O. Quesenberry | | | | 23B. DATE SIGNED 2-22-71 | |
| 23C. PHYSICIAN'S NAME (Type) William O. Quesenberry | | | | 23D. ADDRESS MD GEN. HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 2/26/71 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith | |
| 24D. LOCATION Balto., Md. | | 24E. NAME of REGISTRAR Schinner Funeral Home, Inc., 3331 Brehms Lane, Balto., Md. 21213 | | 24F. FUNERAL DIRECTOR Schinner Funeral Home, Inc., 3331 Brehms Lane, Balto., Md. 21213 | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | 25B. NAME OF REGISTRAR James E. Jones | | 25C. FUNERAL DIRECTOR Schinner Funeral Home, Inc., 3331 Brehms Lane, Balto., Md. 21213 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 71 2047 | |
|---|---|---|---|--|--|---|--|
| BIRTH NO. S-160 | | 71 2047 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Sieber, christian Frank | | | | 2. DATE AND HOUR OF DEATH Feb-23-71, 20:30(PM) M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY Balto | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore Gen Hospital | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 7009 Bank St. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-5-95 | | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. |
| 13. FATHER'S NAME Frank (dec) | | | | 14. MOTHER'S MAIDEN NAME Theresa (dec) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | | | 16. SOCIAL SECURITY NO. 214-01-1922-A | | 17. INFORMANT Patient's chart. | | ADDRESS |
| 18. 519.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (Pseudo- | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (B) Monas) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) Chr obstructive lung disease | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb-22-1971 to Feb-23-1971 that (I) (we) last saw the deceased alive on 2-23-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Yung Soo Pang | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-23-71 | |
| 23C. PHYSICIAN'S NAME (Type) YUNG SOO PANG | | | | 23D. ADDRESS South Baltimore Gen Hosp | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 2/26/71 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | 25B. NAME OF REGISTRAR Dale E. [unclear] | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc., 3331 Brehms Lane, Balto., Md. 21213 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

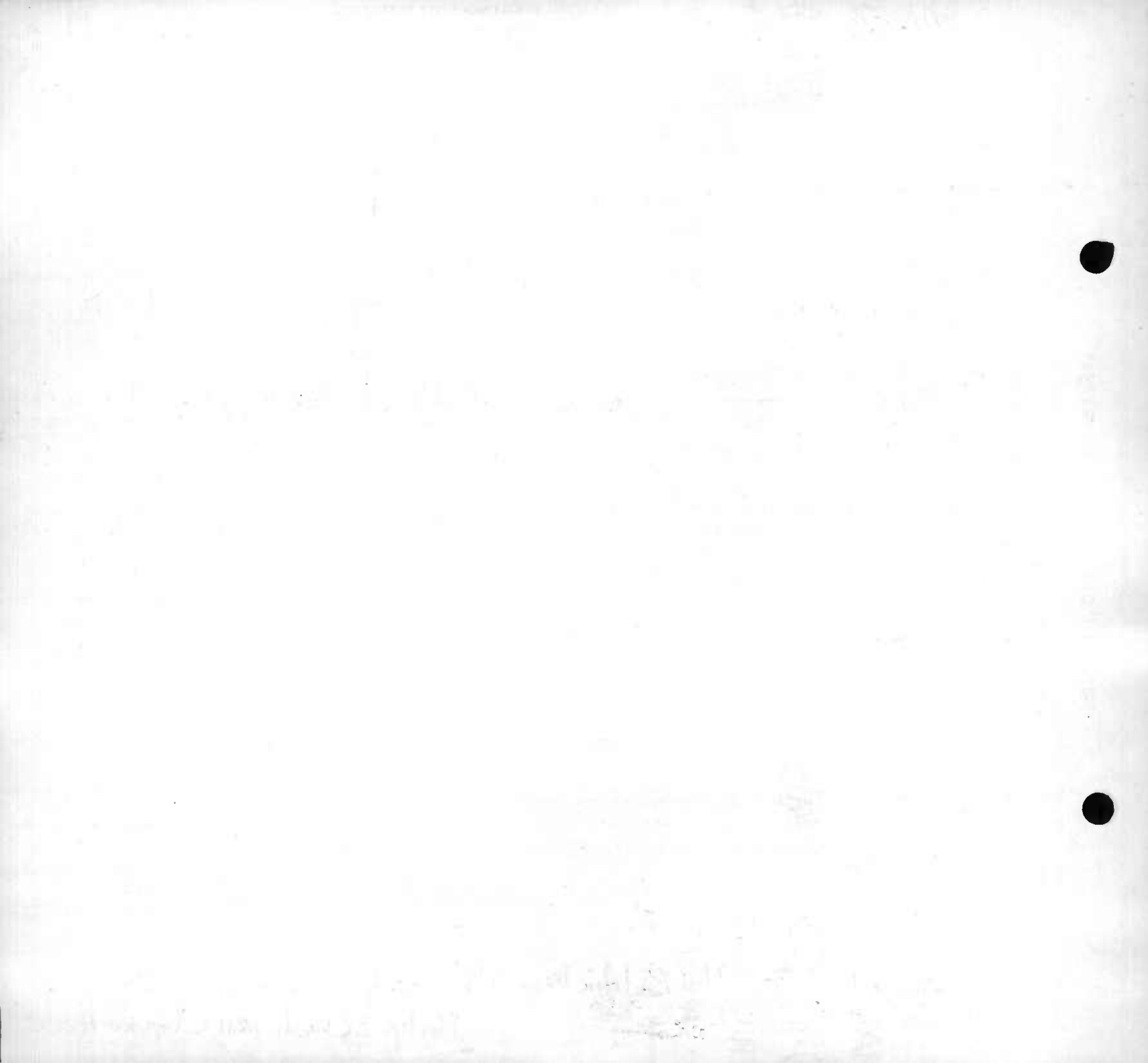
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. <u>71 2048</u> | | CERTIFICATE OF DEATH | | REG. NO. <u>71 2048</u> | |
|---|--|--|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>Mrs. Goldie Pointer</u> | | | | 2. DATE AND HOUR OF DEATH <u>Feb. 27, 1971</u> <u>8:30</u> A.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Keswick Home for Incurables of Balto. City. 700 W. 40th St.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>13-07</u> | | | | | |
| 5. SEX <u>F</u> | | | | 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/11/88</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book-Keeper-Manager</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Meat Packer</u> | | 9. AGE (In years last birthday) <u>82</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u> | |
| 13. FATHER'S NAME <u>Harvey T. Funk</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Katie Mary Hamp</u> | | | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>219-20-7037-4</u> | | 17. INFORMANT <u>Keswick Files</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>153.31-250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Carcinomatosis</u> | | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>CH F, Diabetes mellitus</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Months</u> | | | |
| 19A. DATE OF OPERATION <u>2-6-71</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cs. of Sigmoid</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> 19 <u>66</u> to <u>Feb 27</u> 19 <u>71</u> and that (I) (we) lost saw the deceased alive on <u>Feb 27</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>RK Gundry</u> | | | | 23B. DATE SIGNED <u>2-27-71</u> | | | | 23C. PHYSICIAN'S NAME (Type) <u>RK GUNDY</u> | |
| 23D. ADDRESS <u>2 W University Pkwy</u> | | | | 23E. DEGREE <u>21218</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. DATE <u>3/2/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 2 1971</u> | | | | 25B. NAME OF FUNERAL HOME <u>McCurdy Funeral Home</u> | | 25C. FUNERAL DIRECTOR <u>McCurdy Funeral Home</u> | | | |
| 25D. ADDRESS <u>Balto. Md. 21225</u> | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | REG. NO. | 71 2049 | |
|---|--|--|--|--|----------|--|--|
| M-540 | | 71 2049 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| RUTH E. MANLEY | | 2-26-71 12:02 P. M. | | The Johns Hopkins Hospital | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. CITY OR TOWN | | 6. INSIDE CITY LIMITS? | | | |
| Maryland | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 7. STREET AND NUMBER | | 8. BIRTHPLACE (State or foreign country) | | | | | |
| 1910 Wilhelm Avenue | | Maryland | | | | | |
| 9. SEX | | 10. RACE | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 12. DATE OF BIRTH | |
| F | | W | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 1-16-30 | |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14. KIND OF BUSINESS OR INDUSTRY | | 15. AGE (In years last birthday) | | 16. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| Homemaker | | | | 41 | | | |
| 17. FATHER'S NAME | | 18. MOTHER'S MAIDEN NAME | | 19. CITIZEN OF WHAT COUNTRY? | | | |
| Joseph Wagner | | Ruth Thompson | | USA | | | |
| 20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 21. SOCIAL SECURITY NO. | | 22. INFORMANT ADDRESS | | | |
| No | | Unknown | | Wilbur L. Manley 1910 Wilhelm Ave | | | |
| 23. CAUSE OF DEATH | | 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| Rheumatic Heart Disease | | 18 yrs | | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| 26. MEDICAL CERTIFICATION | | 27. MEDICAL CERTIFICATION | | 28. MEDICAL CERTIFICATION | | 29. MEDICAL CERTIFICATION | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | YES | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-23 1971 to 2-26 1971, that (I) (we) last saw the deceased alive on 2-26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| Bruce A. Reitz MD | | | | 2-26-71 | | BRUCE A. REITZ MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | | | 3-1-71 | | Baltimore Memorial Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR ADDRESS | |
| Belair, Maryland | | | | Philip E. Crach | | 1211 Chesapeake Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2050 | |
|--|--|---|--|---|--|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">Carrie R. Rahl1</div> | | 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> Feb. 26, 1971 1:00 p M. </div> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION 6000 York Road Baltimore, Md. 21212 </div> <div style="flex: 1;"> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div> | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) <div style="display: flex;"> <div style="flex: 1;"> A. STATE Maryland </div> <div style="flex: 1;"> B. COUNTY 27-12 </div> </div> | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hat Trimmer | | 10B. KIND OF BUSINESS OR INDUSTRY Hat | | 8. DATE OF BIRTH Aug. 12, 1894 | |
| 13. FATHER'S NAME David Kotmeier | | 14. MOTHER'S MAIDEN NAME Marie E. Dreisch | | 9. AGE (In years last birthday) 76 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-48-3415 | | 17. INFORMANT John H. Rahl1 (Husband) Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH Hypertensive Arteriosclerotic Cardio-Vascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 4-12-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1956 to Feb. 1971, that (I) last saw the deceased alive on Jan. 1971 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wm. H. Kammer Jr. | | | | 23B. DATE SIGNED 26 Feb. 71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. William H. Kammer, Jr. | | | | 23D. ADDRESS 6011 York Road Balto. Md. 21212 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/1971 | | 24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial Gardens | |
| 24D. LOCATION (City, town, or county) (State) Cockeysville, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 2, 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Road Seitz Funeral Home Balto. Md. 21212 | | | |

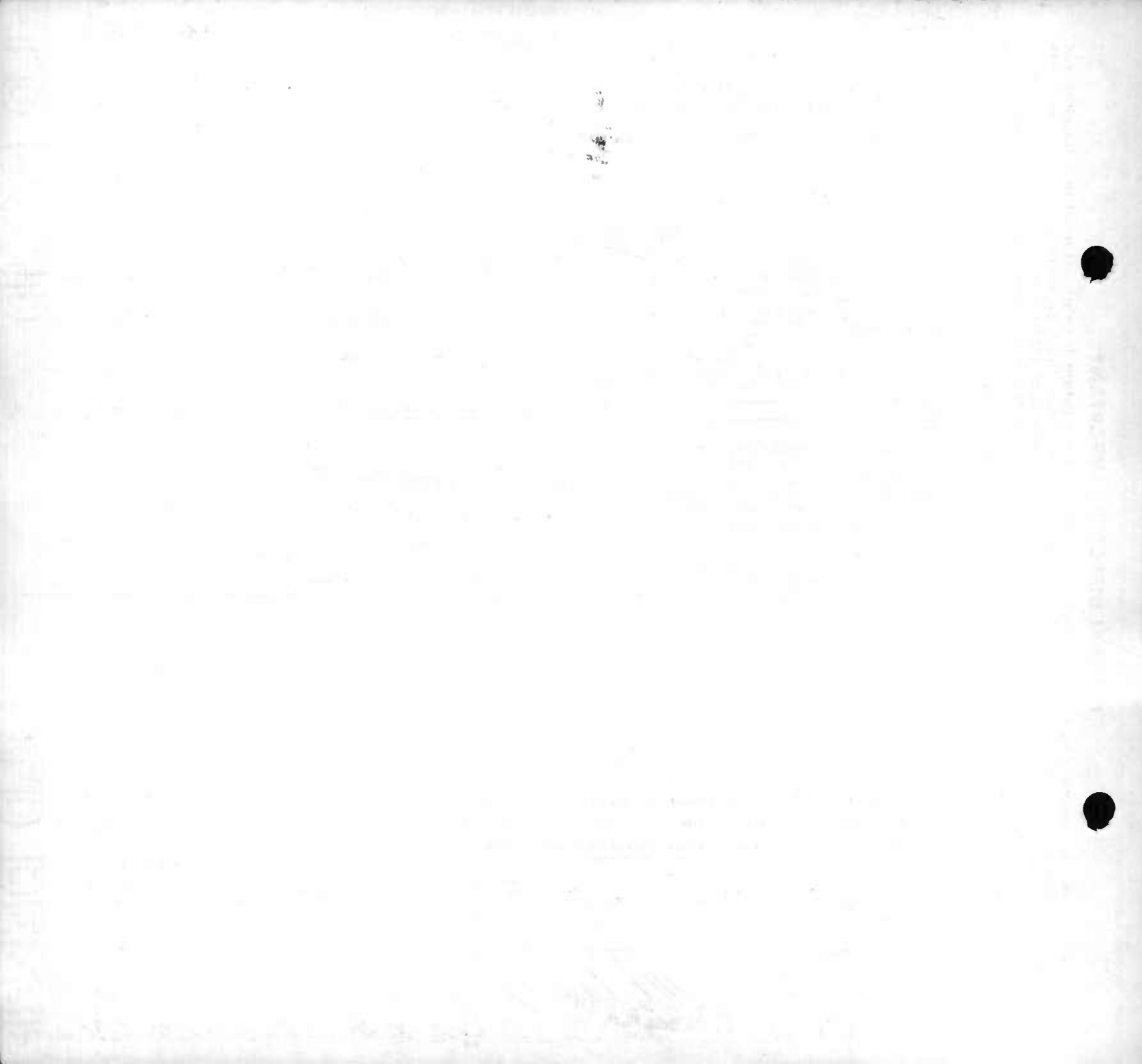
Handwritten text, possibly a signature or date, located in the upper left quadrant.

Handwritten text, possibly a signature or date, located in the lower right quadrant.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

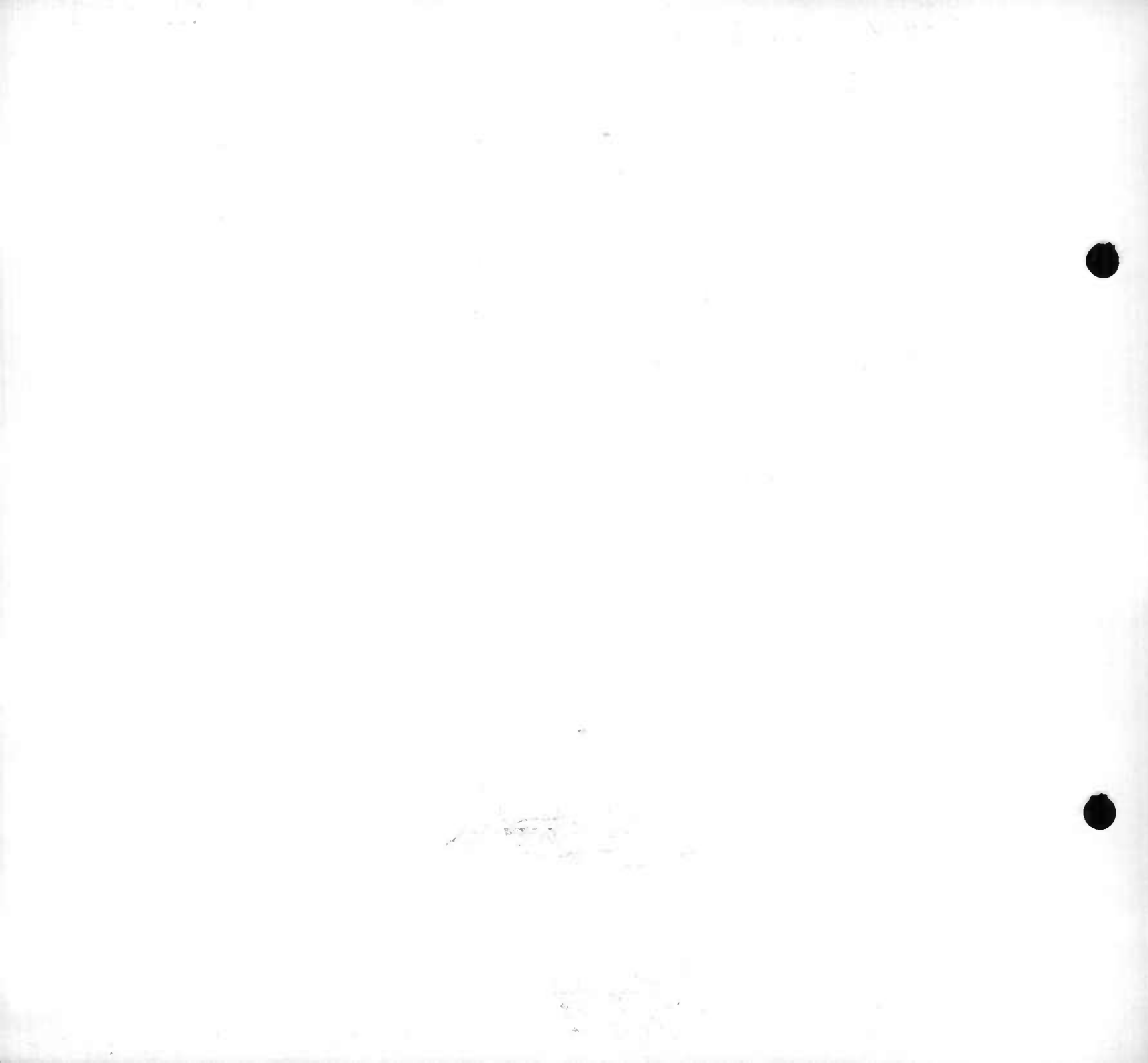
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 2051</u> | |
|---|-------------------------|---|-----------------------------------|--|-----------------------------|--|--|
| BIRTH NO. <u>B-460</u> | | | | 71 2051 | | | |
| 1. NAME OF DECEASED (Type or Print) <u>King James Blair</u> | | | | 2. DATE AND HOUR OF DEATH <u>Feb. 25, 1971</u> <u>6</u> AM. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY _____ | | | |
| | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>727 Aisquith St.</u> | | <u>10-02</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-5-03</u> | 9. AGE (In years last birthday) <u>67</u> | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>? UNKNOWN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>? UNKNOWN</u> | | 11. BIRTHPLACE (State or foreign country) <u>Lester S.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>? UNKNOWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MANDA ?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>240-01-4117</u> | | 17. INFORMANT <u>Mr. James Blair 2107 Edmonson Ave.</u> | | ADDRESS | |
| 18. <u>303.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST. PNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ANEMIA MALNUTRITION</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ALCOHOLISM dehydration</u> | | | | CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (N) (this hospital) attended the deceased from <u>1/18</u> 19 <u>71</u> to <u>2/25</u> 19 <u>71</u> . that (H) (we) last saw the deceased alive on <u>2/25</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour end from the causes stated above. (N) (We) (did) (didn't) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Patrick A. Moloney M.D.</u> | | | | 23B. DATE SIGNED <u>2/25/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Patrick A. Moloney M.D.</u> | |
| 23D. ADDRESS <u>1000 N. E. Preston</u> | | | | 23E. FUNERAL DIRECTOR <u>SCRUGGS</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>2-3-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>St. Calvary Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Arundel Co., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 2 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>SCRUGGS</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|---|---|-------------------------------------|---|--|
| 7-450 | | 71 2052 | | 71 2052 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) FLYNN MRS. ANNA R. | | 2. DATE AND HOUR OF DEATH 3-1-71 at 4:10 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MD. B. COUNTY BALTIMORE | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION BON SECOUR HOSPITAL | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 4621 OLD FREDERICK ROAD | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-18-'95 | 9. AGE (in years lost birthday) 76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME ROBERT REANEY | | | |
| 14. MOTHER'S MAIDEN NAME ANNIE T. KINSELLA | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. 212-20-9405 | | 17. INFORMANT ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH intestinal obstruction because of ca. Lt. Colon + HASEVD + Severe Anemia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: The same | | | |
| (B) Ca of Lt. Colon DUE TO, OR AS A CONSEQUENCE OF: | | (C) The above Cause | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). chronic anemia and mal absorption due to the above disease and paralytic obstruction of intestine | | | | | |
| 19A. DATE OF OPERATION 2/19/71 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED intestinal obstruction | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none | 21C. WHERE DID INJURY OCCUR? none | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) none | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-6-1971 to 3-1-1971 that (I) (we) last saw the deceased alive on 2-28-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. F. Kazemj | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-1-71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Fendou KAZEMJ | | 23D. ADDRESS BON SECOUR HOSPITAL BALTIMORE, Md. 21243 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 3/4/71 | 24C. NAME OF CEMETERY or CREMATORY LOUDON PARK | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | 25C. FUNERAL DIRECTOR Bitke & Co. | | ADDRESS Catonsville 1630 Edmondson Ave | |



| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) CLARENCE H. FLEURY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Feb. 27, 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year February 27, 1971 3:45 P.M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH June 28, 1892 | | 10. AGE (In years, months, days, hours, minutes) 78 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Jos. Fleury, Sr. | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Machinist | |
| 15. MOTHER'S MAIDEN NAME Margaret Magdalene Utz | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Mrs. Lillian May Fleury, 420 Academy Rd. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | DATE SIGNED 2/28/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar. 2, 1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT MAR 2, 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, R.D. | |
| 25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Av., Balto., Md. 21228 | | ADDRESS | |

ACADEMY BOND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

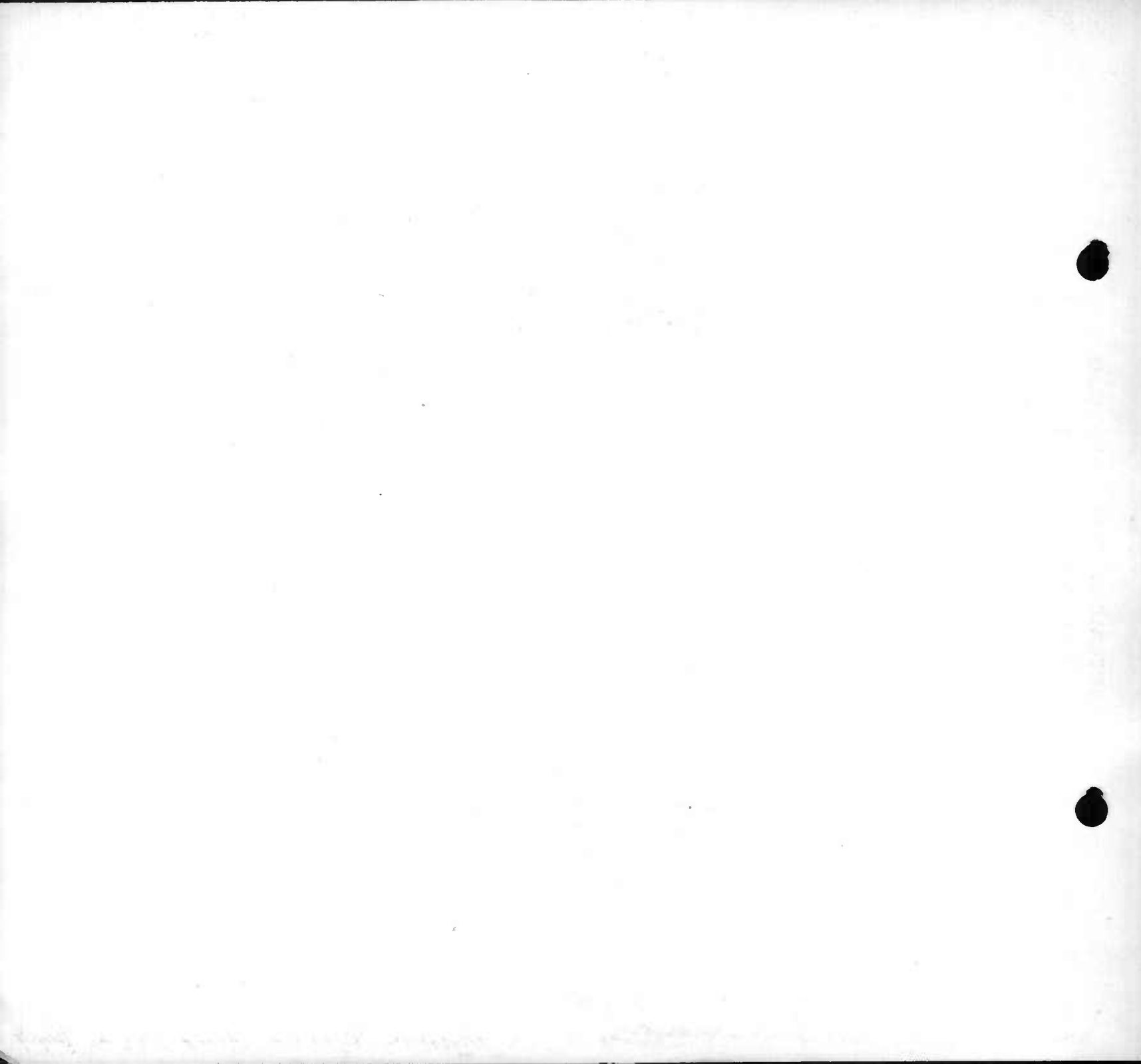
| BIRTH NO. <u>N-220</u> <u>71</u> <u>2054</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>71</u> <u>2054</u> | |
|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>Nowakowski, Ignatius</u> | | | | 2. DATE AND HOUR OF DEATH <u>March, 1, 1971</u> <u>1:10 AM.</u> <u>M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>2-01</u> | | | |
| 5. SEX <u>M</u> | | | | 6. RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>7-3-90</u> | | | | 9. AGE (in years last birthday) <u>80</u> | | 10. UNDER 1 Yr. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>POLAND</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>ANTHONY NOWAKOWSKI</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>213-10-3177</u> | | 17. INFORMANT <u>Baltimore City Hospitals</u> | |
| 18. <u>4/2/4</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE <u>Cardiorespiratory arrest</u> <u>Few minutes</u> | | | |
| ANTECEDENT CAUSES | | | | (B) <u>Sever recurrent Pneumonia</u> <u>Few months</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) <u>ASCVD, CHF & Post CVA @ S. side</u> <u>Few yrs.</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | <u>hem. Paralysis & CBS.</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>10/20</u> 19 <u>70</u> to <u>3/1</u> 19 <u>71</u> that <u>XX</u> (we) lost saw the deceased alive on <u>Feb. 28</u> 19 <u>71</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>K. AFSARI M.D.</u> | | | | 23B. DATE SIGNED <u>March 11, 71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Khosrow AFSARI</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 24B. DATE <u>3/4/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>HOLY ROSARY</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 2 1971</u> | | | | 25B. NAME OF REGISTRAR <u>John W. Weber</u> | | 25C. FUNERAL DIRECTOR <u>401 S. CHESTER ST.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2055 | |
|---|---------------------|---|-------------------------------------|---|---|
| CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) LAMIANI MR. JOSEPH. | | 2. DATE AND HOUR OF DEATH 2/26/71 12:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CHURCH HOME AND HOSPITAL. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL. | | C. CITY OR TOWN BALTIMORE. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 125 S. BROADWAY. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/12/01 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) ITALY | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME SALVADORE LAMIANI. | | | |
| 14. MOTHER'S MAIDEN NAME GRACE FRANCIS LOMBARDI | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 911-18-1930 | | 17. INFORMANT ADDRESS DORIS HILES, 6908 BRADFORD CT LAUREL | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia shock. Pulmonary edema. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II | | | | | |
| 19A. DATE OF OPERATION 2/22/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Rhizotomy | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-6- 19 71 to 2-26- 19 71 and that (I) (we) last saw the deceased alive on 2/26/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE T. S. Ramamurthy | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) T. S. FREE RAMAMURTHY | |
| 23D. ADDRESS CHURCH HOME AND HOSPITAL | | 24A. BURIAL, CREMATION, REMOVAL (Specify) 3-2-71 Holy Redeemer | | | |
| 24B. DATE 3-2-71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS Frank Della Noce 372 S High | |

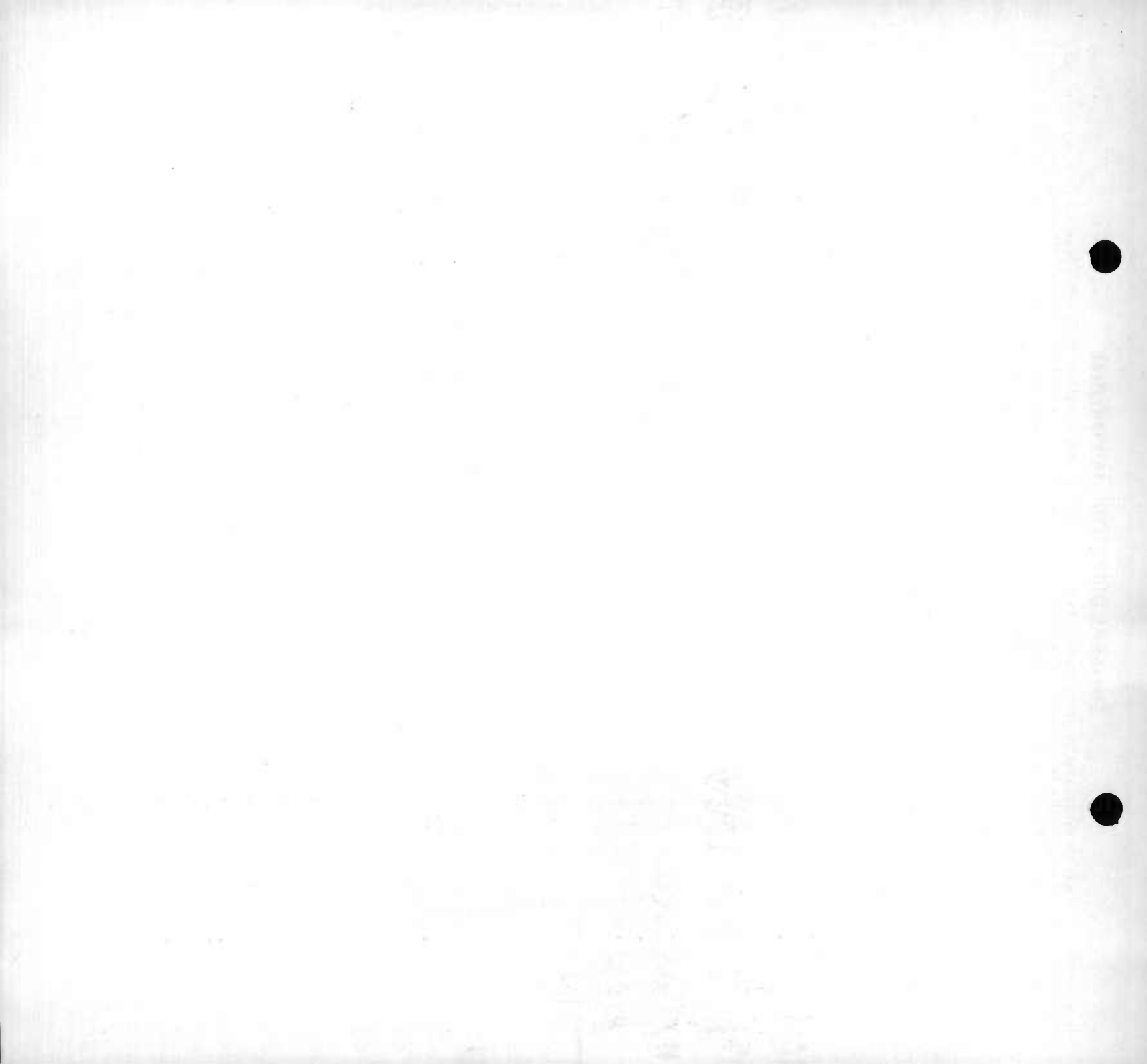


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to a medical examiner. Also, if the direct or contributing cause of death was determined, the certificate must show: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 2056

REG. NO. 71 2056

VS 150-REV. 1/1/68



M-320712057

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

712057

BIRTH NO.

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Matthews, Milton B. | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 1 Year 71 Hour 11:10 a. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital | | 3. DATE PRONOUNCED DEAD Month 3 Day 1 Year 71 Hour 11:10 a. M. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | |
| 9. DATE OF BIRTH 6-7-27 | | 10. AGE (In years lost birthday) 43 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Male Nurse | | 14B. KIND OF BUSINESS OR INDUSTRY Hospital | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II | | 17. SOCIAL SECURITY NO. 216-20-5183 | |
| 18. INFORMANT Milton V. Matthews | | ADDRESS Apt 1A 3901 Wabash Ave. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stabwounds of abdomen ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOUSE | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3616 Milford Ave. (rear porch) | | 22F. HOW DID INJURY OCCUR? Stabbed by unknown assailant. | |
| 22D. TIME OF INJURY (APPROX.) Month 3 Day 1 Year 71 2:25a. m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/1/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-5-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR Wm C March | | ADDRESS 928 E. North Ave. | |

1

C-245

71 2058

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2058

BIRTH NO.

REG. NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) JOHN CHISLON, JR. | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Rear Porch, 941 W. Fayette Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour February 21, 1971 4:15 A.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| 9. DATE OF BIRTH 11-28-37 | | 10. AGE (In years last birthday) 33 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John Chislon | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME Addie Randall | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. 212-36-0791 | | 18. INFORMANT ADDRESS Paul W. Carrington 1416 N. Broadway | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of Head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Porch | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 941 W. Fayette Street | | 22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 2-21-71 3:55 A. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Shot while breaking and entering | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | DATE SIGNED 2/21/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem. | | 24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. March 2, 1971 | | 25B. NAME OF REGISTRAR Robert E. Carley, R.D. | |
| 25C. FUNERAL DIRECTOR Wm C March | | ADDRESS 928 E. North Ave. | |

N 8 3 4 7 1 0 3 0 2 0 5 7

11-24-37

Washington, D.C.

Dear Sir:

Reference is made to your letter of 11-24-37.

RECEIVED NOV 24 1937

Very truly yours,

J. Edgar Hoover

Special Agent in Charge

Enclosure

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|---------|---|--|
| <div style="display: flex; justify-content: space-between;"> H-536 71 2059 </div> | | | |
| <div style="display: flex; justify-content: space-between;"> MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 2059 </div> | | | |
| BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | |
| WILLIAM HENDERSON | | Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 3. DATE PRONOUNCED DEAD | |
| 2904 Walbrook Ave. | | Month Day Year Hour 2 25 1971 6:35 P.M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| A. STATE Md. B. COUNTY | | | |
| 6. SEX | 7. RACE | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| male | negro | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | C. CITY OR TOWN | |
| 4-9-13 | | Balto. | |
| 10. AGE (In years lost birthday) | | D. INSIDE CITY LIMITS? | |
| 57 | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 11. BIRTHPLACE (State or foreign country) | | E. STREET AND NUMBER | |
| North Carolina | | 2904 Walbrook Ave. 13-06 | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| | | William Henderson | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME | |
| | | Dinkey Jeffers | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| | | 218-01-2728 | |
| 18. INFORMANT | | ADDRESS | |
| Jeffers Henderson | | 2219 Guilford Ave | |
| 19. CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fatty liver | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) | | | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 2 | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED | |
| | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 23. | | 22F. HOW DID INJURY OCCUR? | |
| | | Part. | |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER | |
| Isidore Mihalakis, M.D. | | ASSOCIATE MEDICAL EXAMINER | |
| | | DATE SIGNED | |
| | | 2-26-71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| Burial | | 3-3-71 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Mt Auburn Cemetery | | Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| MAR 2, 1971 | | Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |
| Wm C March | | 928 E. North Ave. | |

STANDARD LIFE AND ACCIDENT INSURANCE CO. OF NEW YORK

William Thompson

North Carolina

Henry Jackson

210-01-2785 Jackson, Henry

Y. S. S.

Partial 5-3-1

St. Andrew Cemetery

Belle...

St. Andrew Cemetery 222 E. North Ave.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| ANNA CLAGGETT | | Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | |
| Maryland General Hospital | | 2 25 1971 | | 7:45 p | | | |
| 6. SEX | | 7. RACE | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. DATE OF BIRTH | |
| female | | negro | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 2-15-01 | |
| 10. AGE (In years) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF | | 13. FATHER'S NAME | |
| lost birthday 70 | | Va. | | U.S.A. | | 426 Cummings Court | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| | | Ella Young | | no | | Mary Johnson | |
| 18. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | 19. INFORMATION | | 20. ADDRESS | | 21. AUTOPSY? (Yes or No) | |
| A. STATE Md. | | B. COUNTY | | 2133 Chelsea Ter. | | no | |
| 22. CAUSE OF DEATH | | 23. MEDICAL CERTIFICATION | | 24. DATE OF OPERATION | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| Arteriosclerotic cardiovascular disease | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 26. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| (A) IMMEDIATE CAUSE | | (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | 28. TIME (Month) (Day) (Year) (Hour) | | 29. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| DUE TO, OR AS A CONSEQUENCE OF: | | ANTECEDENT CAUSES | | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 30. HOW DID INJURY OCCUR? | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | 31. ACTUAL SIGNATURE | | 32. DATE SIGNED | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | Isidore Mihalakis, M.D. | | 2-26-71 | |
| Diabetes mellitus | | 33. BURIAL CREMATION, REMOVAL (Specify) | | 34. DATE | | 35. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3-1-71 | | Mt. Auburn Cem. | | 36. LOCATION (City, town, or county) (State) | |
| 37. DATE REC'D BY HEALTH DEPT. | | 38. NAME OF REGISTRAR | | 39. FUNERAL DIRECTOR | | 40. ADDRESS | |
| MAR 2 1971 | | Robert E. Faber, M.D. | | V. Bailey | | 1348 Calhoun Street | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| T-460 71 2061 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | 71 2061 | |
|---|-------------------------|--|--|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Morris E. Taylor</i> | | 2. DATE AND HOUR OF DEATH <i>25 February 1971 4¹⁵ A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hosp</i> | | E. STREET AND NUMBER <i>107 S. Monastery Ave.</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>Male</i> | 6. RACE <i>Negro</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3 Jan. 1910</i> | 9. AGE (In years last birthday) <i>61</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Mattress Factory</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>?</i> | | 14. MOTHER'S MAIDEN NAME <i>Rebecca ?</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-05-7489</i> | | 17. INFORMANT <i>Dorothy Taylor (Wife) - same</i> | |
| 18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Renal Failure</i> | | | |
| | | (C) <i>ASCVD & chronic CHF</i> | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Cerebrovasc. Accident</i> | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>2/7</i> 19 <i>71</i> to <i>2/25</i> 19 <i>71</i> that (1) (we) last saw the deceased alive on <i>2/25</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Louis H. Shapiro, MD</i> | | 23B. DATE SIGNED <i>25 Feb 1971</i> | | 23C. PHYSICIAN'S NAME (Type) <i>LOUIS H. SHAPIRO</i> | |
| 23D. ADDRESS <i>University Hospital</i> | | 23E. F. DEGREE | | 23F. ADDRESS <i>University Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-1-71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i> | |
| 24D. LOCATION <i>Baltimore, Md.</i> | | 24E. DATE REC'D BY HEALTH DEPT. <i>MAR 2 1971</i> | | 24F. NAME OF REGISTRAR <i>Kelson F.H.</i> | |
| 24G. FUNERAL DIRECTOR <i>V. Bailey</i> | | 24H. ADDRESS <i>1348 Calhoun Street</i> | | 24I. ADDRESS <i>1348 Calhoun Street</i> | |

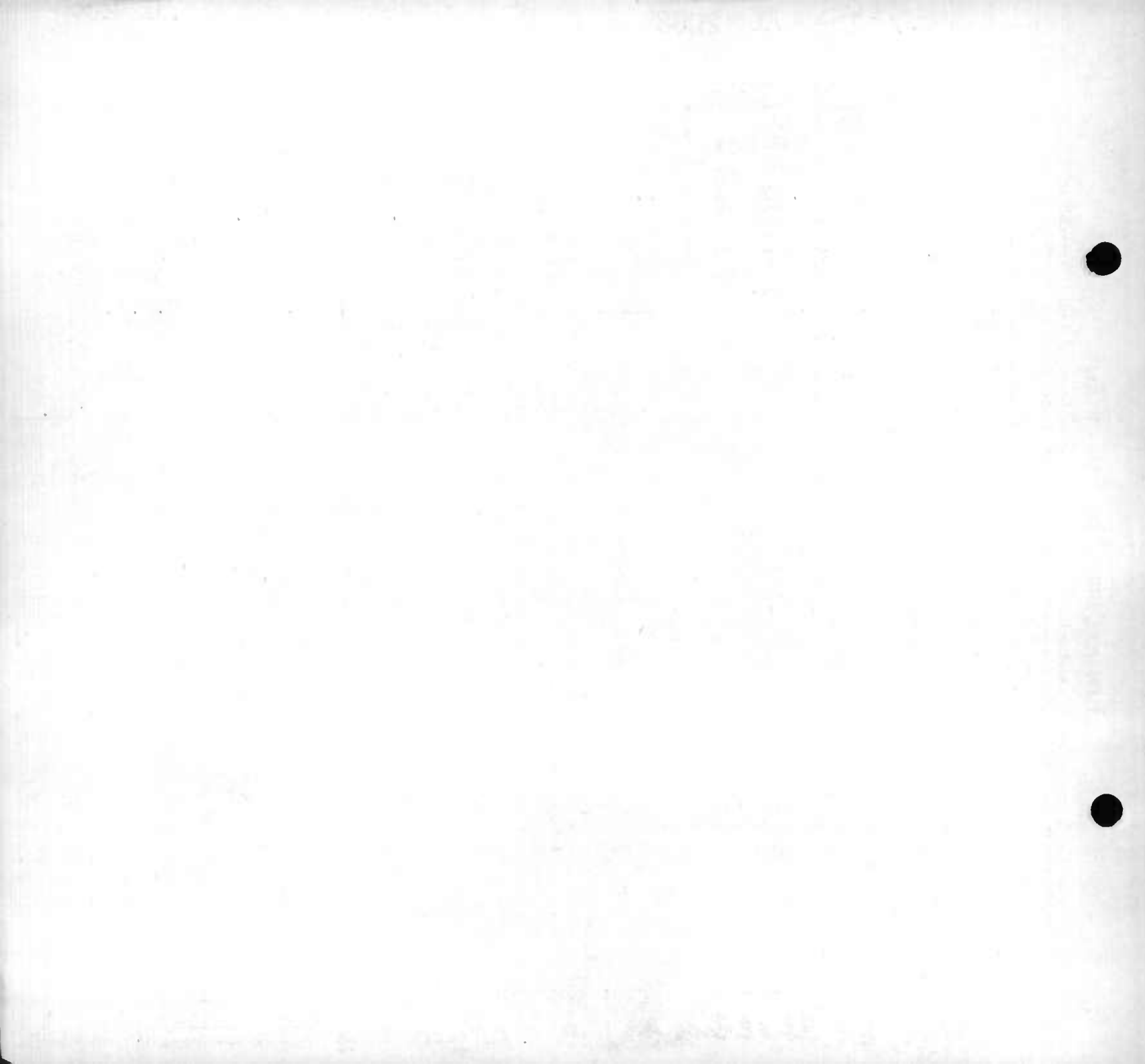
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2062</u> | |
|--|------------------|---|---|--|--|
| BIRTH NO. <u>D-200</u> | | 71 2062 | | | |
| 1. NAME OF DECEASED (Type or Print) <u>DIGGS, MARY E.</u> | | | 2. DATE AND HOUR OF DEATH <u>2 28 71 9:45 PM</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSP.</u> <u>730 ARHBURTON ST BALTO MD 21216</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____ C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>424 N EDGEWOOD ST.</u> <u>20-37</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9 5 89</u> | 9. AGE (In years last birthday) <u>81</u> | If Under 1 Yr. Months _____ Days _____ If Under 24 Hrs. Hours _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Ind.</u> | |
| 13. FATHER'S NAME <u>ALBERT JOHNSON</u> | | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH JOHNSON</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mary Mason - same</u> ADDRESS _____ | |
| 18. <u>4/10/71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction w/ Pulmonary Edema</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction w/ Pulmonary Edema</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb 28 19 70</u> to <u>Feb 28 19 70</u> that (I) (we) lost saw the deceased alive on <u>Feb 28 19 70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>G. C. MARFORI</u> | | | 23B. DATE SIGNED <u>2/28/71</u> | | 23C. PHYSICIAN'S NAME (Type) _____ |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>3-4-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l. Cem.</u> |
| 24D. LOCATION <u>Balto., Md.</u> | | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 2 1971</u> | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | | 25C. FUNERAL DIRECTOR <u>Y. BAILEY</u> ADDRESS <u>1348 Calhoun St.</u> | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2063 | |
|---|-------------------------|---|--|---|---|
| 1. NAME OF DECEASED (Type or Print) Fannie Brown | | | 2. DATE AND HOUR OF DEATH Feb. 26, 1971 M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2002 W. Fayette St. | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 2002 W. Fayette St. | | 6-04 |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-26-91 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cook | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (State or foreign country) Burnsville, Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME ----- | | | 14. MOTHER'S MAIDEN NAME ----- | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 214-01-6777 | 17. INFORMANT Linwood Brown ADDRESS 2038 Walbrook Ave. | | |
| 18. 424.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure (B) C. valvular disease of heart (C) arteriosclerosis with hypertension | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days over 7 years over 7 years |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-26-1961 to 2-26-1971 , that (I) we last saw the deceased alive on 2-19-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John E. T. Camper, M.D. | | | | 23B. DATE SIGNED 3-1-71 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN E. T. CAMPER M.D. | | 23D. ADDRESS 6391 Gray St Baltimore Maryland 21214 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 1-2-71 | Carver Memorial Park | | Laurel, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | 25B. NAME OF REGISTRAR Paul E. Johnson | | 25C. FUNERAL DIRECTOR Vernon Bailey ADDRESS Kelson Funeral Home 1348 N. Calhoun | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| K-450 71 2064 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2064 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) KILLIAN, GEORGE P. - Sr. | | 2. DATE AND HOUR OF DEATH 2-28-71 9PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY B. 5118 Greenwich Av. Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 5118 Greenwich Ave. 28-54 | | | |
| 5. SEX male | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-21-05 | 9. AGE (in years last birthday) 66 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Steelrule Die Co. - Washington, D.C. | | 11. BIRTHPLACE (State or foreign country) U.S. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME George P. Killian | | 14. MOTHER'S MAIDEN NAME Marie Kremb | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 578-09-3644 | | 17. INFORMANT Mrs. C. Virginia Killian | |
| | | | | ADDRESS 5118 Greenwich | |
| 18. 13779 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ca. Stomach | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2-14-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-14-1971 to 2-28-1971 that (I) (we) last saw the deceased alive on 2-28-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Govinda Rao | | 23B. DATE SIGNED 11-0 | | 23C. PHYSICIAN'S NAME (Type) Dr. R. Govinda Rao | |
| | | 23D. ADDRESS Lutheran Hospital of Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/4/71 | | 24C. NAME of CEMETERY or CREMATORY National Memorial Park Cen. - Falls Church, Va. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taber, R.D. | | 25C. FUNERAL DIRECTOR Stading Funeral Estate Address | | | |
| 25D. ADDRESS 3736 Edmondson Ave. Catonsville, Md. 21228 | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

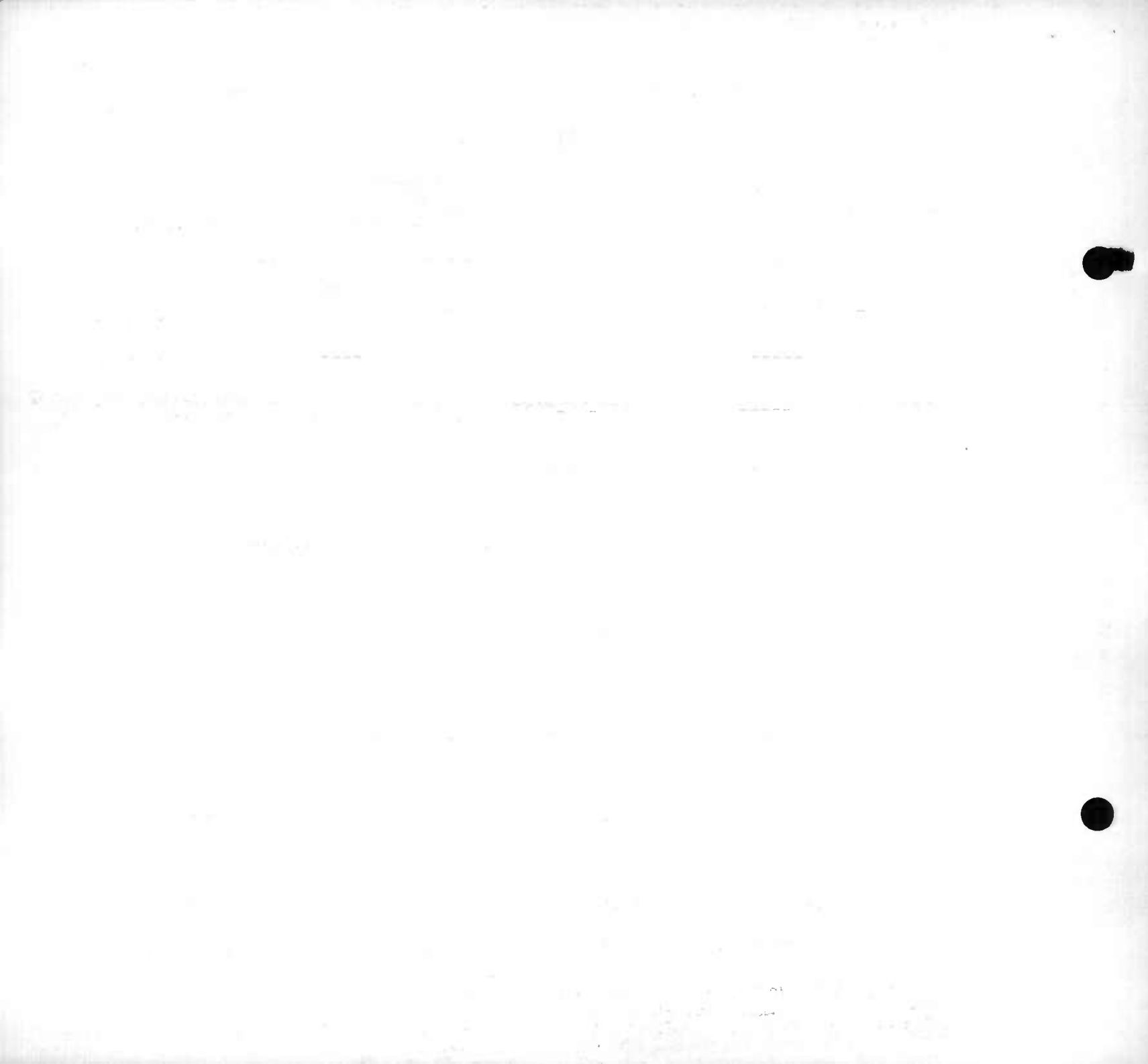
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| 71 2065 REG. NO. 71 2065 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | |
| BIRTH NO. R-163 1. NAME OF DECEASED (Type or Print) Mary ROBERTS, PATRICIA K. | | 2. DATE AND HOUR OF DEATH FEBRUARY 27, 1971 11:20 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MD. 21229 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 305 GUN ROAD 21227 | |
| 5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 06/27/28 9. AGE (In years last birthday) 42 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10B. KIND OF BUSINESS OR INDUSTRY HOMEMAKER | | 11. BIRTHPLACE (State or foreign country) MARYLAND - Baltimore 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME PHILLIP KIRWAN 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) NO | | 14. MOTHER'S MAIDEN NAME MABEL (CONNOLLY) 16. SOCIAL SECURITY NO. 220-22-5174 17. INFORMANT BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE. | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) metastatic breast car- cino to the liver, spleen & verte- bral column. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE metastatic breast car- DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 03 1971 to FEBRUARY 27 1971 that (I) (we) last saw the deceased alive on FEBRUARY 27 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE H. GUZMAN M.D. 23B. DATE SIGNED 2/27/71 23C. PHYSICIAN'S NAME (Type) HORACIO GUZMAN, M.D. 23D. ADDRESS 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3/2/71 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1971 25B. NAME OF REGISTRAR Robert E. Sabes, M.D. 25C. FUNERAL DIRECTOR Seeding Funeral Estate ADDRESS 1736 Edmondson Ave. Catonsville, Md. 21228 | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| G-300 71 2066 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2066 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) Richard P. Goode | | | 2. DATE AND HOUR OF DEATH February 26, 1971 6:45 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2516 N. Calvert Street Baltimore, Maryland 21218 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-03 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2516 N. Calvert Street Balto., Md. 21218 | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/2/1880 | 9. AGE (in years last birthday) 91 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Automobile | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME ----- (Unknown) | | 14. MOTHER'S MAIDEN NAME ----- (Unknown) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No ----- | | 16. SOCIAL SECURITY NO. 215-12-5375 | | 17. INFORMANT ADDRESS Baltimore, Md. 21207 Mrs. Ruth Leitch, 6510 Windsor Mill Road, | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 43791 Cerebro-Vascular Disease - weeks? (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Arteriosclerosis - months? (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ----- II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Generalized Arterio Sclerosis Over 4 years. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 21, 1971 to Feb. 26, 1971 that (I) (we) last saw the deceased alive on Feb. 26, 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Frank N. Ogden M.D. DEGREE | | | | 23B. DATE SIGNED Feb. 26, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) Frank N. Ogden M.D. DEGREE | | 23D. ADDRESS 2701 N. Calvert Street Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/71 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | 24F. NAME OF REGISTRAR Loring Byers | |
| 24G. FUNERAL DIRECTOR Loring Byers | | 24H. ADDRESS 728 Liberty Road Randallstown 21133 | | | |



71 2067

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2067

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) William X Dunbar | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 2 26 71 6:20 p M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2227 McHenry St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 26 71 6:20 p M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 12-26-1902 | | 10. AGE (In years lost birthday) 68 | |
| 11. BIRTHPLACE (State or foreign country) England | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | 15. MOTHER'S MAIDEN NAME | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 213 01 4607A | |
| 18. INFORMANT Mrs Margaret Gross | | ADDRESS 3730 Falls Rd Balto Md | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE OF DEATH UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Partial Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 2/26/71 DATE SIGNED | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-1-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Moreland Mem Ph Cem | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT MAR 2 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, R.S. | |
| 25C. FUNERAL DIRECTOR Thomas J. Kenny Inc | | ADDRESS 1600 Hollins St | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2068 | | 71 2068 | |
|--|-------------------------|---|--|---|--|---|--|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mariah Ladeau</i> | | | | 2. DATE AND HOUR OF DEATH <i>February 28, 1971 5:50 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i> | | | | A. STATE <i>MD.</i> | | B. COUNTY | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <i>822 Abbott Court</i> | | <i>10-02</i> | |
| 5. SEX <i>Female</i> | 6. RACE <i>Black</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Oct. 11, 1901</i> | 9. AGE (in years last birthday) <i>69</i> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>S. Carolina</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>George Ladeau</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Annie Ann?</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Elizabeth Proulx</i> | |
| | | | | ADDRESS <i>1709 Leland St.</i> | | | |
| 18. <i>410.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CORONARY THROMBOSIS</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>IMMEDIATE</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <i>HYPERTENSION</i> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) <i>CARDIO VASCULAR DISEASE</i> | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/20</i> 19 <i>67</i> to <i>2/28</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>2/23</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Albert R. Lafortest</i> | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>3/1/71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>ALBERT L. LAFOREST MD</i> | | | | 23D. ADDRESS <i>822 N. Bond St Baltimore MD 21205</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>3/4/71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>St. Stephen S.C.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 2 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert J. Elickson</i> | | 25C. FUNERAL DIRECTOR <i>1129 N. Calver</i> | | | |

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7-422 71 2069 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2069 REG. NO.

BIRTH NO.

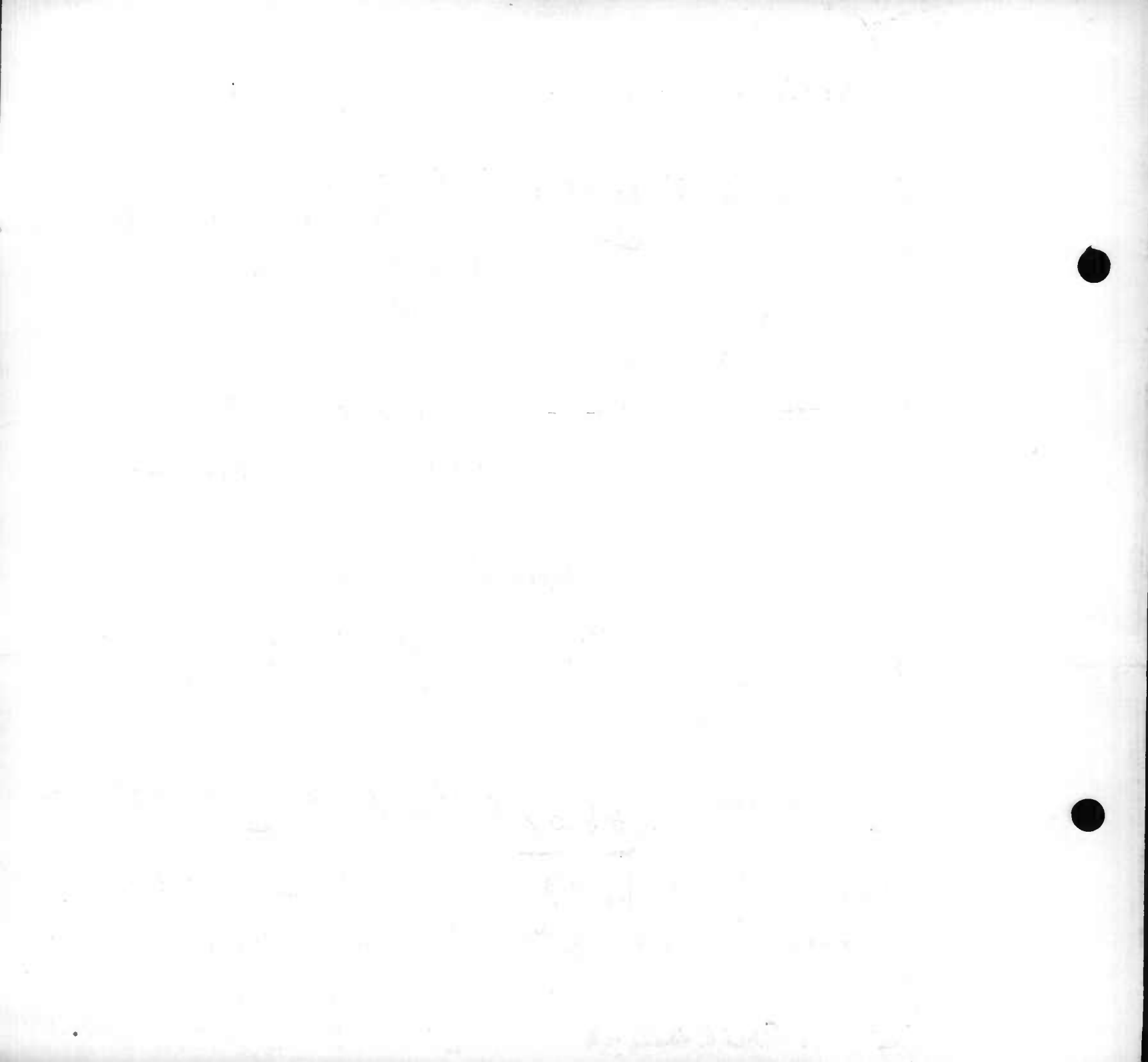
| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) EVERETT L. FOWLKES | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2130 Boulton St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 25 1971 2:50 p.m. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. CITY OR TOWN Balto. | |
| 10. DATE OF BIRTH 5-9-43 | | 11. AGE (In years lost birthday) 27 | |
| 12. BIRTHPLACE (State or foreign country) Maryland | | 13. CITIZEN OF WHAT COUNTRY? USA | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labrwr | | 15. KIND OF BUSINESS OR INDUSTRY 13-02 | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Sallie Brown | | ADDRESS 718 Capital Ave | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E965X | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wounds of head DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 21. DATE OF OPERATION 2 | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 23. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 25. TIME OF INJURY (APPROX.) 2-24-71 | | 26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 27. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2130 Boulton St. 13-02 | | 28. HOW DID INJURY OCCUR? Shot by unknown assailant. | |
| 29. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 30. ACTUAL SIGNATURE Isidore Mihalakis, M.D. | | 31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 32. DATE SIGNED 2-26-71 | | | |
| 33. BURIAL CREMATION, REMOVAL (Specify) Burial | | 34. DATE 3-2-71 | |
| 35. NAME OF CEMETERY or CREMATORY Arbutus MPP. | | 36. LOCATION (City, town, or county) (State) Arbutus, Md. | |
| 37. DATE REC'D BY HEALTH DEPT. MAR 2 1971 | | 38. NAME OF REGISTRAR Robert E. Fowlkes | |
| 39. FUNERAL DIRECTOR Edw. N. 1129 N. Market | | ADDRESS | |

VS 151-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

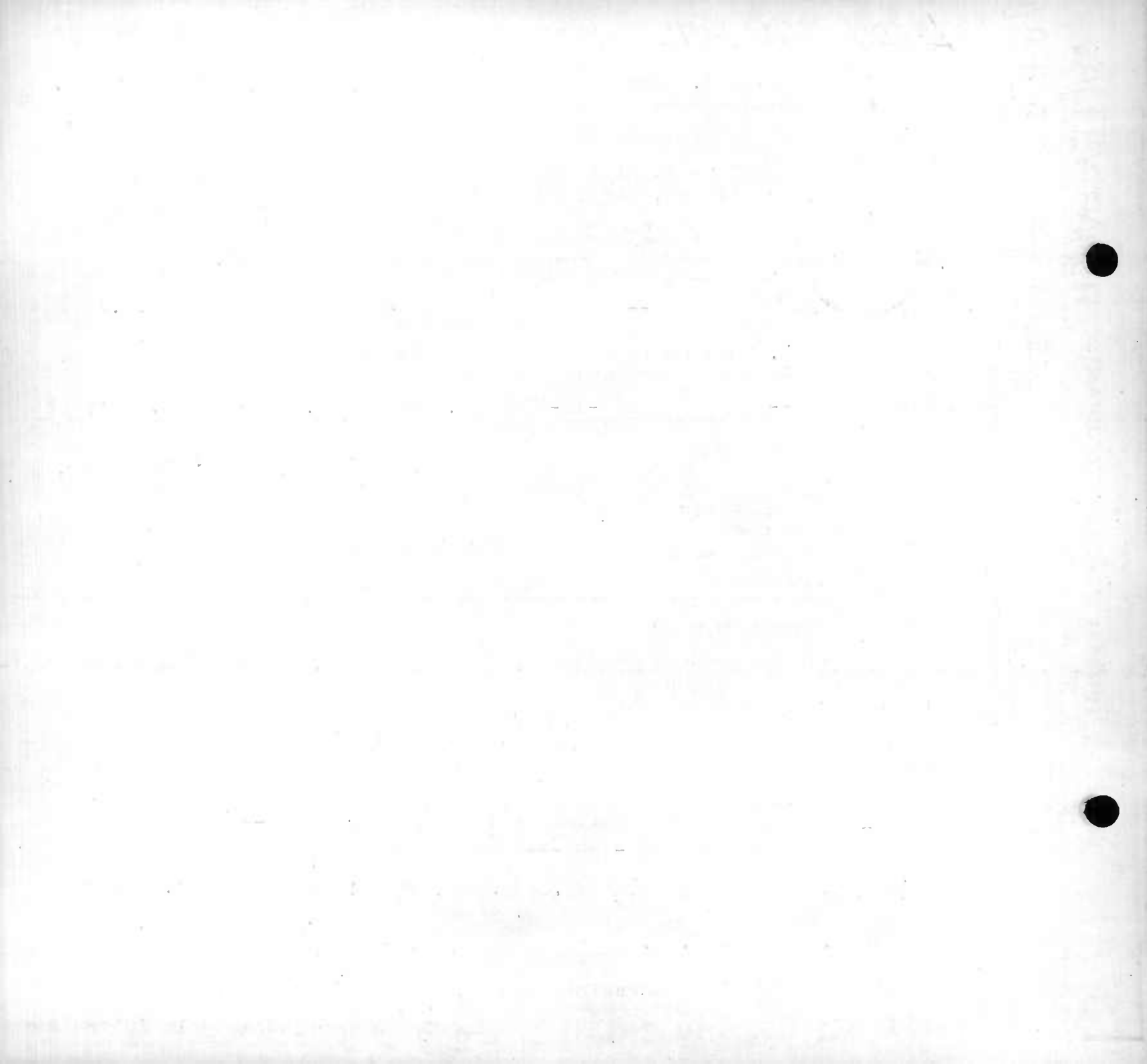
| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 71 2070 | |
|--|-----------|---|-------------------------|--|-------------------------------|--|--|
| BIRTH NO. R-521 71 2070 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MARY CATHERINE RAMSBURG | | | | 2. DATE AND HOUR OF DEATH 2/28/71 12 ⁰⁵ P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GEN. HOSP. | | | | A. STATE MD. B. COUNTY 62-00 | | | |
| | | | | C. CITY OR TOWN FOREST HILL | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 305 FOREST VALLEY DR. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-4-09 | 9. AGE (In years last birthday) 62 | 10. Under 1 Yr. Months: Days: | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Rual Arthur | | | | 14. MOTHER'S MAIDEN NAME Smith | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --- | | | | 16. SOCIAL SECURITY NO. 220-32-3680 | | 17. INFORMANT Hosp. info. sheet | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Thoracic aneurysm, aorta, dissecting 1 mo. | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) Hypertension, ASCVD. 5 yrs. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Superior mesenteric art. embolus 3 d | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 1 19 71 to Feb 28 19 71 that (I) (we) lost saw the deceased alive on Feb 28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Karl F. Meach, Jr. M.D. | | | | 23B. DATE SIGNED 2/28/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) KARL F. MEACH, JR. M.D. | | | | 23D. ADDRESS Md. Gen. Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/3/71 | | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Donovan Funeral Home 3818 Roland Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2071</u> | |
|--|--|--|---|--|---|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Mary M. Lohr | | February 27, 1971 | | 8:00 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| 2917 Cresmont Avenue Baltimore, Maryland | | | Maryland | | |
| 5. SEX | | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| Female | | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| Housewife | | | -- | | Maryland |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| I. Spry Moore | | | Pearl Insley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No -- | | | 220-18-9760 | | Mr. Chester E. Lohr 261 W. 31st St |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 11/25/70 | | Adenocarcinoma of colon | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 19 69 to February 27, 19 71, that (I) (we) last saw the deceased alive on February 25, 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Lloyd E. Saylor, M.D. | | | | Feb. 28, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Lloyd E. Saylor, M. D. | | | | 3902 Greenmount Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 3/2/71 | | Lorraine Park Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 8, 1971 | | Robert E. Saylor | | Donovan Funeral Home 3818 Roland Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2072 | |
|--|---|--|--|--|---|
| BIRTH NO. C-623 71 2072 | | | | | |
| 1. NAME OF DECEASED (Type or Print) MARK CHRISTY | | 2. DATE AND HOUR OF DEATH 2/26/71 11:30 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Gould Convalesarium 6116 Belair Rd. | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 627 Cator Ave. 9-01 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/15/1895 | 9. AGE (In years lost birthday) 75 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Joseph Colbourn | | 14. MOTHER'S MAIDEN NAME Mary Tawes | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-20-7243 | | 17. INFORMANT Joseph Christy - 6011 Winthrope Ave. | |
| 18. 309.91 CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A) IMMEDIATE CAUSE <u>Atelectatic Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Cachexia DUE TO, OR AS A CONSEQUENCE OF: | | weeks | |
| (C) Pneumatic Depression DUE TO, OR AS A CONSEQUENCE OF: | | weeks | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Osteoporosis - Pneumia atelectatica - ULL - Gastric Ulcer Chronic Brain Syndrome - Abdominal Aneurysm | | | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/19/70 to 2/24/71 that (I) (we) last saw the deceased alive on 2/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert B. Bradley | | 23B. DATE SIGNED 2/26/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D. | | 23D. ADDRESS 4900 Belair Rd. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/2/71 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | 25B. NAME OF REGISTRAR Robert C. Altenburg | 25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home Inc. 6009 Harford Rd. - Balto., Md. 21214 | | | |

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K-251

71 2073

BALTIMORE CITY HEALTH DEPARTMENT

71 2073

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|-------------------------|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JOHN KASCHENBACH | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year February 25, 1971 | | M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3722 Fairhaven Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year February 25, 1971 | | Hour 10:05 |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland | | B. COUNTY | | |
| 6. SEX Male | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore |
| 9. DATE OF BIRTH Sept 2 1895 | | 10. AGE (In years lost birthday) 75 | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 11. BIRTHPLACE (State or foreign country) Wilkes Barre Pa | | 12. CITIZEN OF WHAT COUNTRY? | | E. STREET AND NUMBER 3722 Fairhaven Avenue |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY | | 13. FATHER'S NAME John Kaschenbach |
| 15. MOTHER'S MAIDEN NAME Amanda Schappert | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Mrs. Margaret Schevets 1029 Genine Dr | | |
| 19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) Yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED February 25, 1971 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-27-71 | | 24C. NAME of CEMETERY or CREMATORY Sacred Heart of Mary |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | |
| 25B. NAME OF REGISTRAR WALTER DABROWSKI | | 25C. FUNERAL DIRECTOR ADDRESS 1005 DUNDALK AVENUE | | |

MEDICAL EXAMINATION REPORT

DATE: 10/10/2010

TIME: 10:00 AM

10/10/2010

10:00 AM

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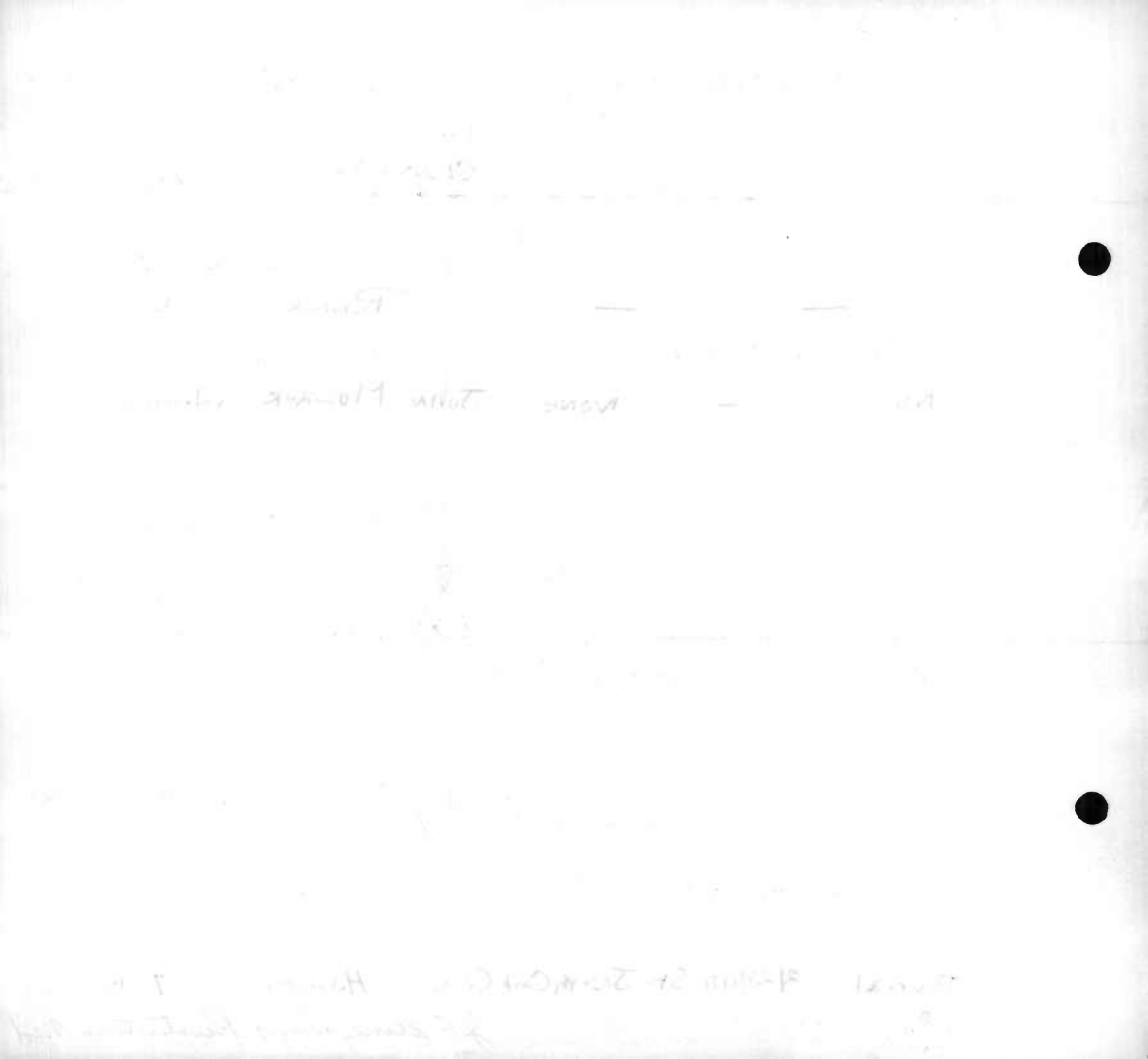
10/10/2010

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|---|--|---|--|---|--|
| 71 2074 CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 71 2074 | | | | | | | | | |
| 11-660 BIRTH NO. <i>Penna.</i> | | 1. NAME OF DECEASED (Type or Print) <i>Mowrer Jennifer R.</i> | | | | 2. DATE AND HOUR OF DEATH <i>2/27/71 12:42 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>univ. Hosp</i> | | | | | | A. STATE <i>PA</i> | | B. COUNTY <i>YORK</i> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | | C. CITY OR TOWN <i>Glenville</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | | | | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>2/12/71</i> | | 9. AGE (in years last birthday) <i>15 days</i> | | If Under 1 Yr. Months Days <i>15</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Penna</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John R. Mowrer</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>Leona Stahl</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | | 16. SOCIAL SECURITY NO. <i>NONE</i> | | 17. INFORMANT <i>John Mowrer</i> | | | |
| | | | | | | ADDRESS <i>Glenville, Pa.</i> | | | |
| 18. <i>746.61</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>congenital cardiac anomalies</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aortic Stenosis, inter ventricular (B) DUE TO, OR AS A CONSEQUENCE OF: Septal defect, and Patent ductus (C) Arteriosclerosis</i> | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Heart failure</i> | | | | | | | | | |
| 19A. DATE OF OPERATION <i>2/27/71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>congenital heart</i> | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/25/71</i> 19 <i>71</i> to <i>2/27</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>2/27</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>E. Shapiro M.D.</i> | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>2/28/1971</i> | | 24C. NAME of CEMETERY or CREMATORY <i>St. Joseph Cath. Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Hanover YORK Pa.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 3 1971</i> | | 25B. NAME OF REGISTRAR <i>Charles J. ...</i> | | 25C. FUNERAL DIRECTOR <i>J. F. ...</i> | | ADDRESS <i>... Rustertown Md.</i> | | | |



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2075

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) JACOB KENNEDY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTO. GENERAL HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour February 27, 1971 5:25 P.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 11-25-38 | | 10. AGE (In years lost birthday) 32 | |
| 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME Dessie Kennedy | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 217-38-7783 | |
| 18. INFORMANT Mary Kennedy | | ADDRESS 132 W. Cross St. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Chronic pericarditis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE [Signature] M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner DATE SIGNED 2/28/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Charles A. Rice | | ADDRESS 661 W. Barre St. | |

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UNITED STATES DEPARTMENT OF THE INTERIOR

WASHINGTON, D. C.

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TO THE SECRETARY

FROM THE

UNITED STATES DEPARTMENT OF THE INTERIOR

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WHITE PAPER

71 2076

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2076

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)R.
Fred Grandison Jr.2. DATE OF DEATH Known ☒ Estimated ☐
Month Day Year Hour
M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
3 2 71 6:45 a. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

6. SEX

male

7. RACE

colored

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1/23/21

10. AGE (In years lost birthday)

50

Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

512 Roberts St.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Fred. R. Grandison

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

~~XXXXXXXXXXXX~~ Magnolia Pittman

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

WW11

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Bernice Minter Philadelphia, P.A.

19. 412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

3/2/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/17/71

24C. NAME OF CEMETERY OR CREMATORY

Pittman

24D. LOCATION (City, town, or county) (State)

Windsor, Va.

25A. DATE REC'D BY HEALTH DEPT.

MAR 3, 1971

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.

ACADEMY FOUNDATION

PAID IN FULL

NO. 10

1964

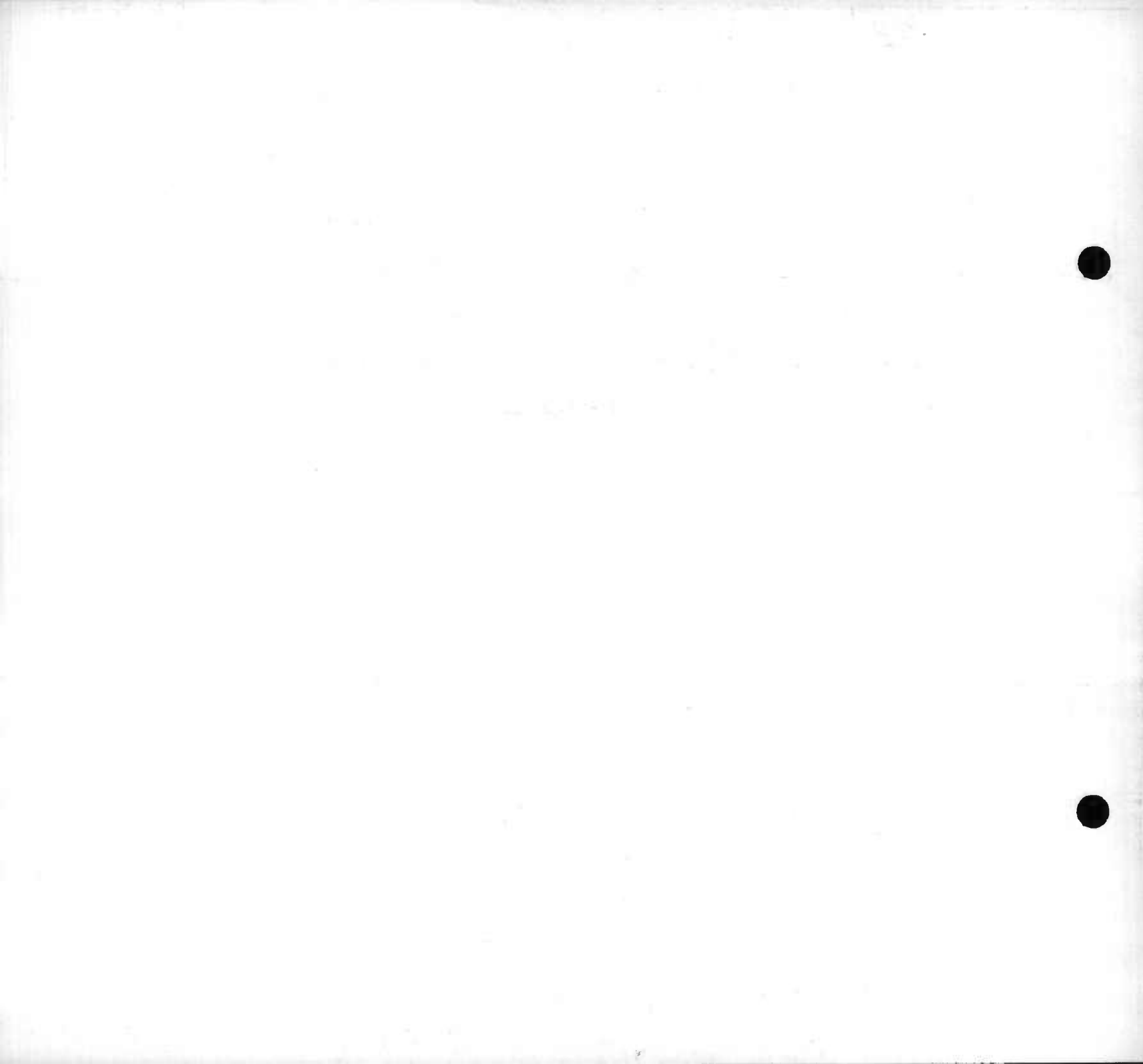
1964

1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

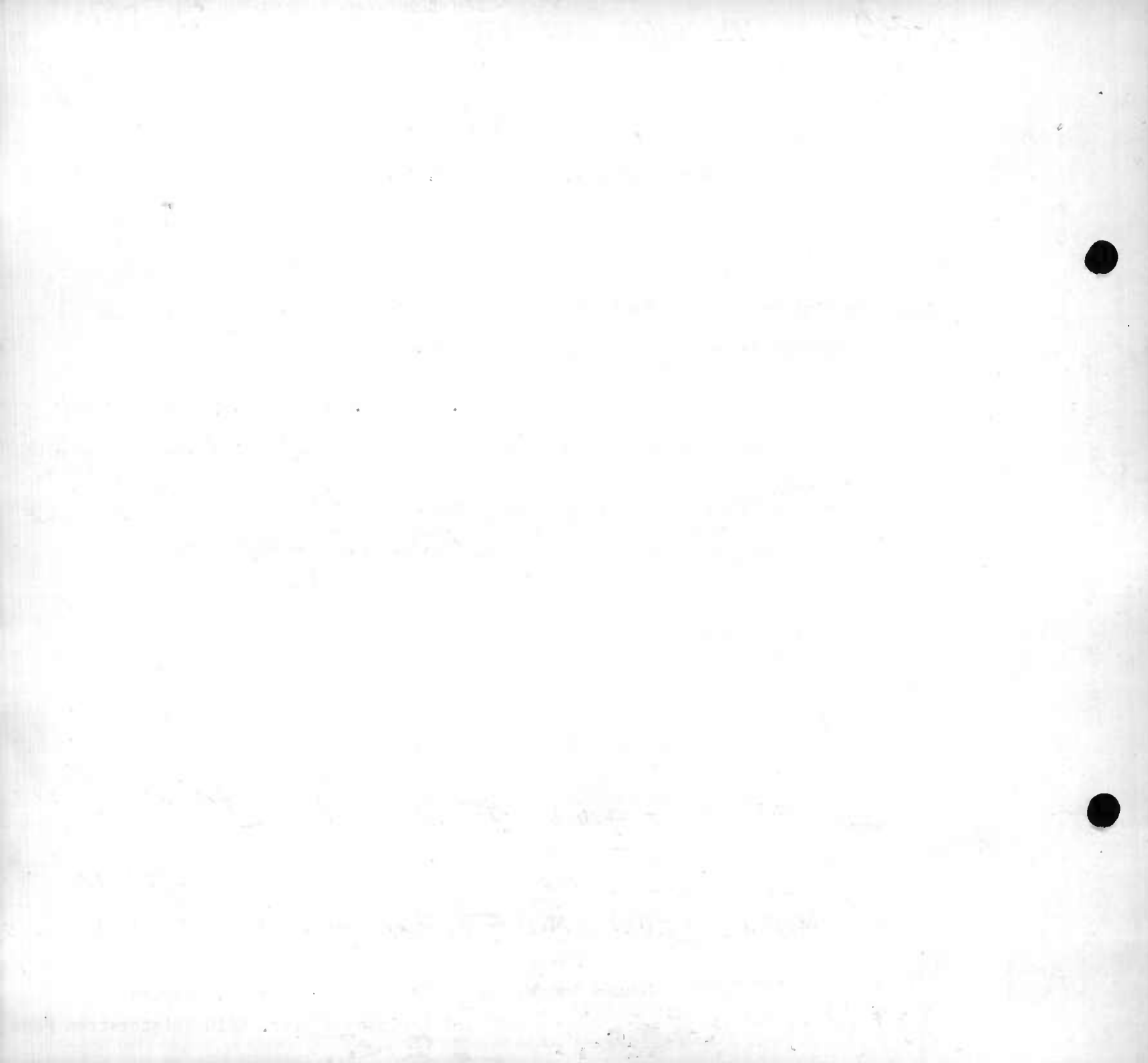
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|---|---|--|---|---|--|
| 71 2077 CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH/NO. <u>ESPERANZO FIGUEROA</u> | | | | | REG. NO. <u>71 2077</u> | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>ESPERANZO FIGUEROA</u> | | | | | 2. DATE AND HOUR OF DEATH <u>2-26-71</u> <u>11:30 P M.</u> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL.</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE.</u> | | | | |
| | | | | | C. CITY OR TOWN <u>BALTIMORE.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER <u>1214 EUTAW PLACE</u> <u>17-02</u> | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-15-88</u> | 9. AGE (in years last birthday) <u>82</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None.</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Spain Cuba</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Ignacio Piedra</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Carmen Martinez</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>226-44-6592</u> | | 17. INFORMANT <u>E.R. RECORD.</u> | | | |
| 18. <u>410191</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Artherosclerotic Cardiovascular Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arterial and Atrial Longphorosis</u> <u>Pulmonary Emboli</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>used</u> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-17</u> 19 <u>71</u> to <u>2-26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>2-26</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Michael Grasso M.D.</u> | | | | | 23B. DATE SIGNED <u>2-26-71</u> | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MICHAEL GRASSO M.D.</u> | | | | | 23D. ADDRESS <u>MARYLAND GENERAL HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-2-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Mecadonia</u> | | 24D. LOCATION (City, town, or county) (State) <u>Bloxom - Accomack, Va.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Samuel S. Savage - New Church, Va.</u> | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

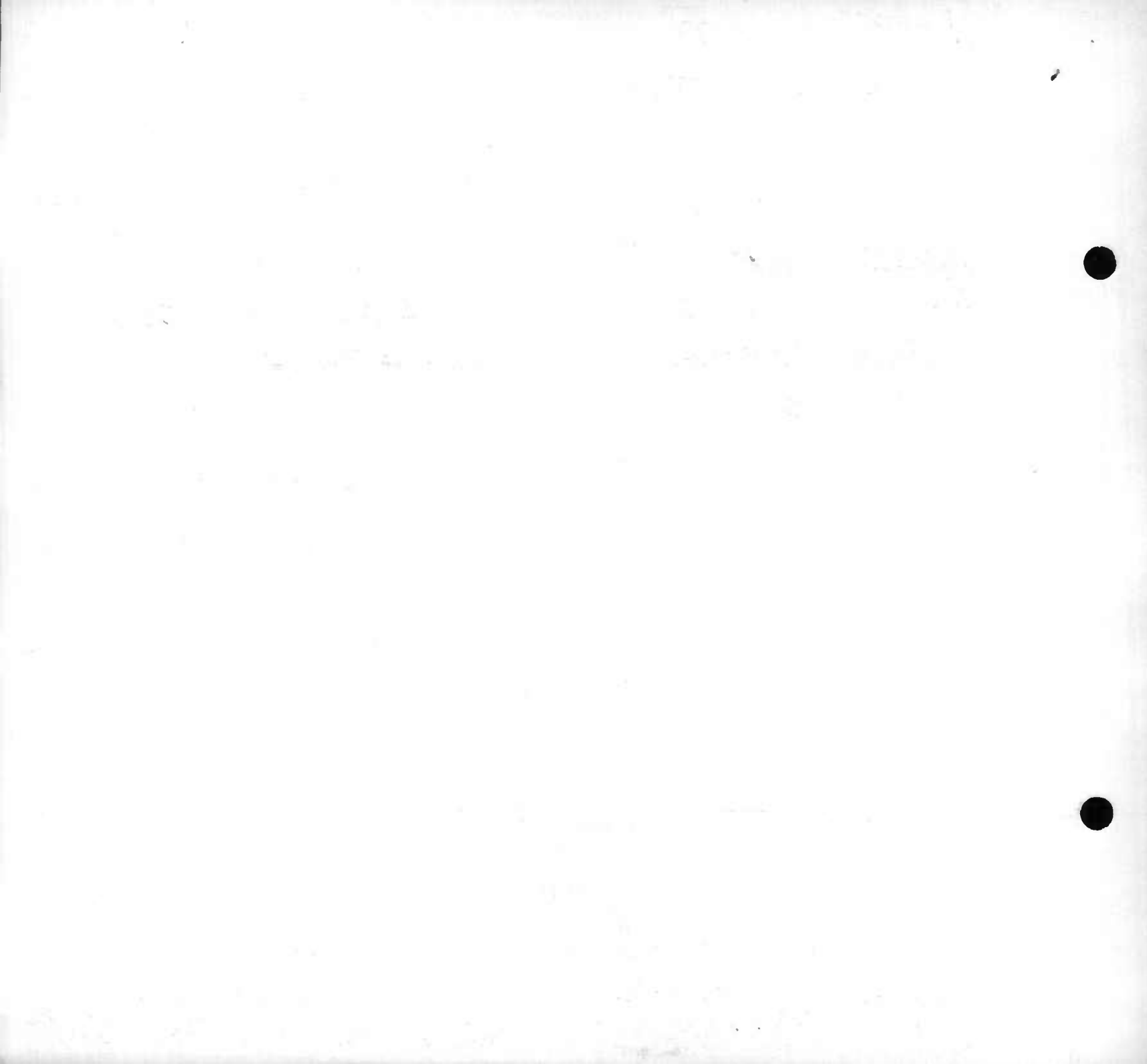
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 71 2078 |
|--|--------------------------------|---|--|--|---------|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>DITLOW ISADORE</i> | | 2. DATE AND HOUR OF DEATH <i>2-27-71</i> <i>3:50 PM</i> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Pleasant Manor Nursing Home</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____ C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>5108 Queensberry Avenue</i> <i>27-17</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>64 yrs</i> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Upholstery</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Factory</i> | | 11. BIRTHPLACE (State or foreign country) <i>Russia</i> | |
| 13. FATHER'S NAME <i>Joseph Ditlow</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mr. Irvin R. Jaslow</i> | |
| 18. 41231 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | CAUSE OF DEATH <i>Atherosclerotic heart disease</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Emphysema obstructive</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>severe & hypoxia & yellow</i> (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>2 years</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 27</i> <i>1971</i> to <i>Feb 27</i> <i>1971</i>, that (I) (we) last saw the deceased alive on <i>Feb 27</i> <i>1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Manuel Levin</i> <i>MD</i> DEGREE | | | | 23B. DATE SIGNED <i>2/27/71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN</i> <i>M.D.</i> DEGREE | | | | 23D. ADDRESS <i>6101 PARK HTS AVE BALTO MD 21215</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/28/1971</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Jehuda Amachby Lodge</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 3 1971</i> | | | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR <i>Sol Levinson & Bros. 6010 Reisterstown Road</i> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

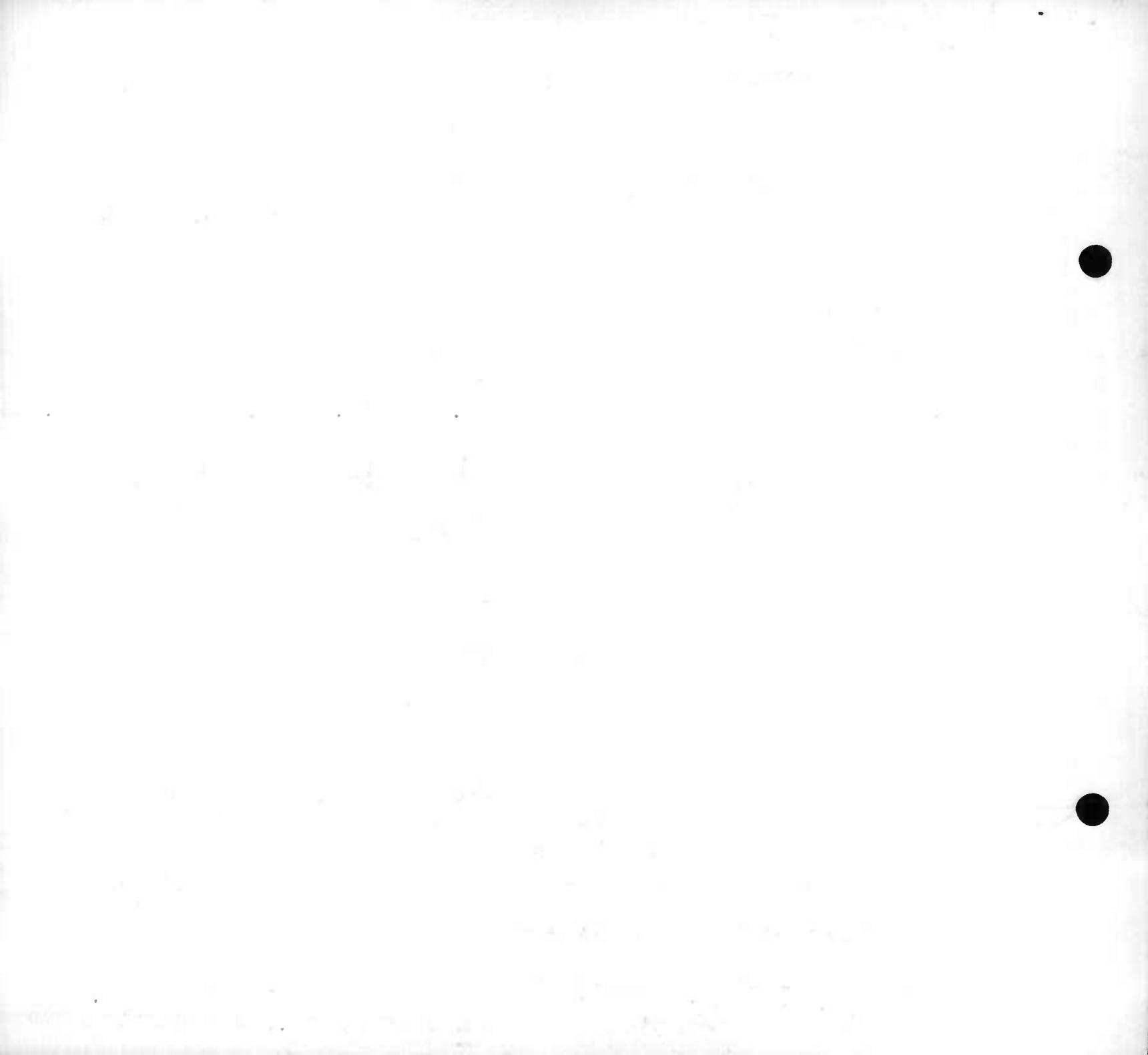
| L-155 71 2079 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2079 | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>Lipman, Jack</u> | | 2. DATE AND HOUR OF DEATH <u>2-27-71 10 am</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>28-31</u> | | | |
| 5. SEX <u>MALE</u> | | 6. RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>3-31-03</u> | | 9. AGE (In years last birthday) <u>67</u> | | 10. UNDER 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>TAVERN</u> | | 11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13. FATHER'S NAME <u>ISAAC LIPMAN</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>RENA PRICE</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. <u>?</u> | | 17. INFORMANT <u>medical chart</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>53291</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>minutes</u> | |
| | | (B) <u>Intestinal obstruction</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>hours</u> | |
| | | (C) <u>Duodenal ulcer</u> | | <u>days</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>post hepatic cirrhosis</u> | | <u>years</u> | | | |
| 19A. DATE OF OPERATION <u>2-8-71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>duodenal ulcer</u> | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 7, 1971</u> to <u>Feb 27, 1971</u> that (I) (we) last saw the deceased alive on <u>Feb 27, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Marcia Waterbury, M.D.</u> | | 23B. DATE SIGNED <u>2-27-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>MARCIA WATERBURY</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>FEB 28/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>AITZ CHAIM</u> | |
| 24D. LOCATION (City, town, or county) <u>BALTIMORE, MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 3, 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | |
| 25C. FUNERAL DIRECTOR <u>INC</u> | | 25D. ADDRESS <u>5612 Robinson</u> | | 25E. PHONE NO. <u>6010 REIST</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| N-332 | | 71 2080 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2080 | |
|--|--|---|--|--|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) XXXXXXXXXX NAIDITCH | | | |
| 2. DATE AND HOUR OF DEATH 2/26/71 12:01 A.M. | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. OF BALTO. | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | A. STATE MD. | | B. COUNTY 27-30 | | C. CITY OR TOWN BALTO. | |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 3018 Falkstaff Manor COURT | | F. SEX FEMALE | | G. RACE WHITE | |
| H. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | I. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | J. DATE OF BIRTH | | K. AGE (In years last birthday) 72 | |
| L. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | M. KIND OF BUSINESS OR INDUSTRY AT HOME | | N. BIRTHPLACE (State or foreign country) RUSSIA | | O. CITIZEN OF WHAT COUNTRY? USA | |
| P. FATHER'S NAME UNKNOWN | | | | Q. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| R. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | S. SOCIAL SECURITY NO. NO | | T. INFORMANT MRS. DOROTHY N. CAPLAN, 3900 GLENGYLE AVE. #15 | |
| U. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I. This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | V. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MENINGO ENCEPHALITIS (B) DUE TO, OR AS A CONSEQUENCE OF: VIRAL (C) _____ | | | |
| W. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | X. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Y. DATE OF OPERATION | | Z. CONDITION FOR WHICH OPERATION WAS PERFORMED | | AA. AUTOPSY? (Yes or No) | | AB. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| AC. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | AD. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | AE. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | AF. HOW DID INJURY OCCUR? | |
| AG. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | AH. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | AI. I certify that (this hospital) attended the deceased from 2/26/71 to 2/26/71 that (we) last saw the deceased alive on 2/26/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | AJ. DATE SIGNED 2/26/71 | |
| AK. SIGNATURE Fortunato V. Elizaga M.D. | | AL. PHYSICIAN'S NAME (Type) FORTUNATO V. ELIZAGA M.D. | | AM. ADDRESS 504 LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | AN. DATE SIGNED 2/26/71 | |
| AO. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | AP. DATE 2-28-71 | | AQ. NAME of CEMETERY or CREMATORY WORKMEN CIRCLE | | AR. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| AS. DATE REC'D BY HEALTH DEPT. MAR 3, 1971 | | AT. NAME of REGISTRAR John E. Jones, M.D. | | AU. FUNERAL DIRECTOR 504 LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | AV. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

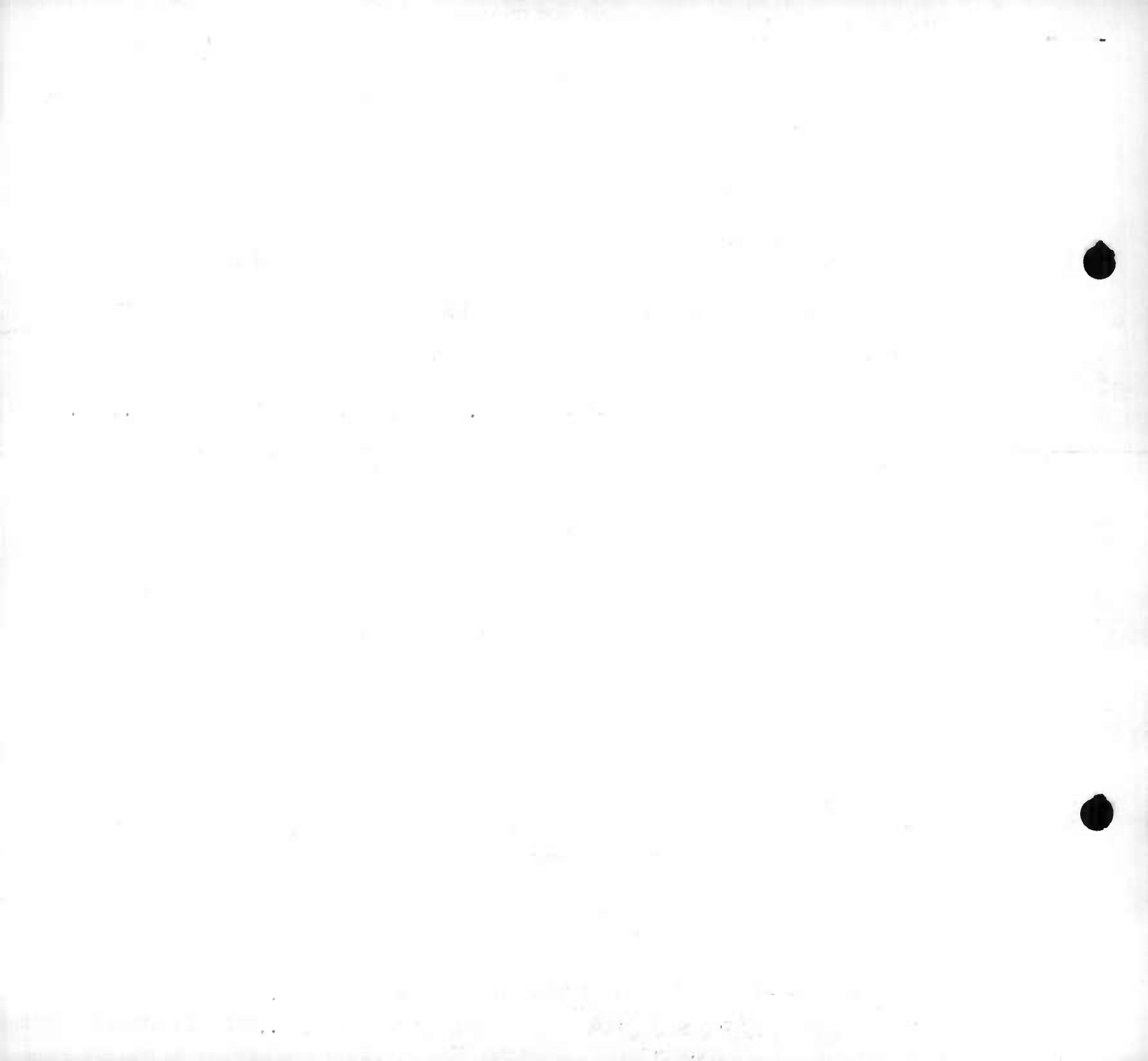
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2081</u> | |
|---|-------------------------|---|--|--|--|
| G-621 71 2081 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>GERSKOV, IRVIN</u> | | 2. DATE AND HOUR OF DEATH <u>2.28.71</u> <u>1.25 P</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>28-31</u> | | |
| | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>6614 VINCENT LANE, APT. 302 #21215</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4. XXX. 1900</u> | 9. AGE (in years last birthday) <u>70</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL RETAIL</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13. FATHER'S NAME <u>ABRAHAM GERSKOV</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>SARAH ?</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. <u>226-16-6388A</u> | | 17. INFORMANT <u>MR. MAX GERSKOV, 6614 VINCENT LANE, APT. 302</u> | | | |
| 18. CAUSE OF DEATH <u>195.914-25019</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>C.H.F.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) Metastatic Ca. of the Neck</u> <u>(C) Diabetes Mellitus - ASCVD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2.11.71</u> 19 <u>71</u> to <u>2.28.71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4:15 PM 2.28.71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>M. Bahadori</u> | | | | 23B. DATE SIGNED <u>2.28.71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MOHAMMAD BAHADORI</u> | | | | 23D. ADDRESS <u>SINAI HOSPITAL of BALTIMORE</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL-BURIAL</u> | | 24B. DATE <u>3-2-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>ATZ CHAIM</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>DANVILLE, VIRGINIA</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>SQL LEVINSON & BROS. 6010 REISTERSTOWN ROAD</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

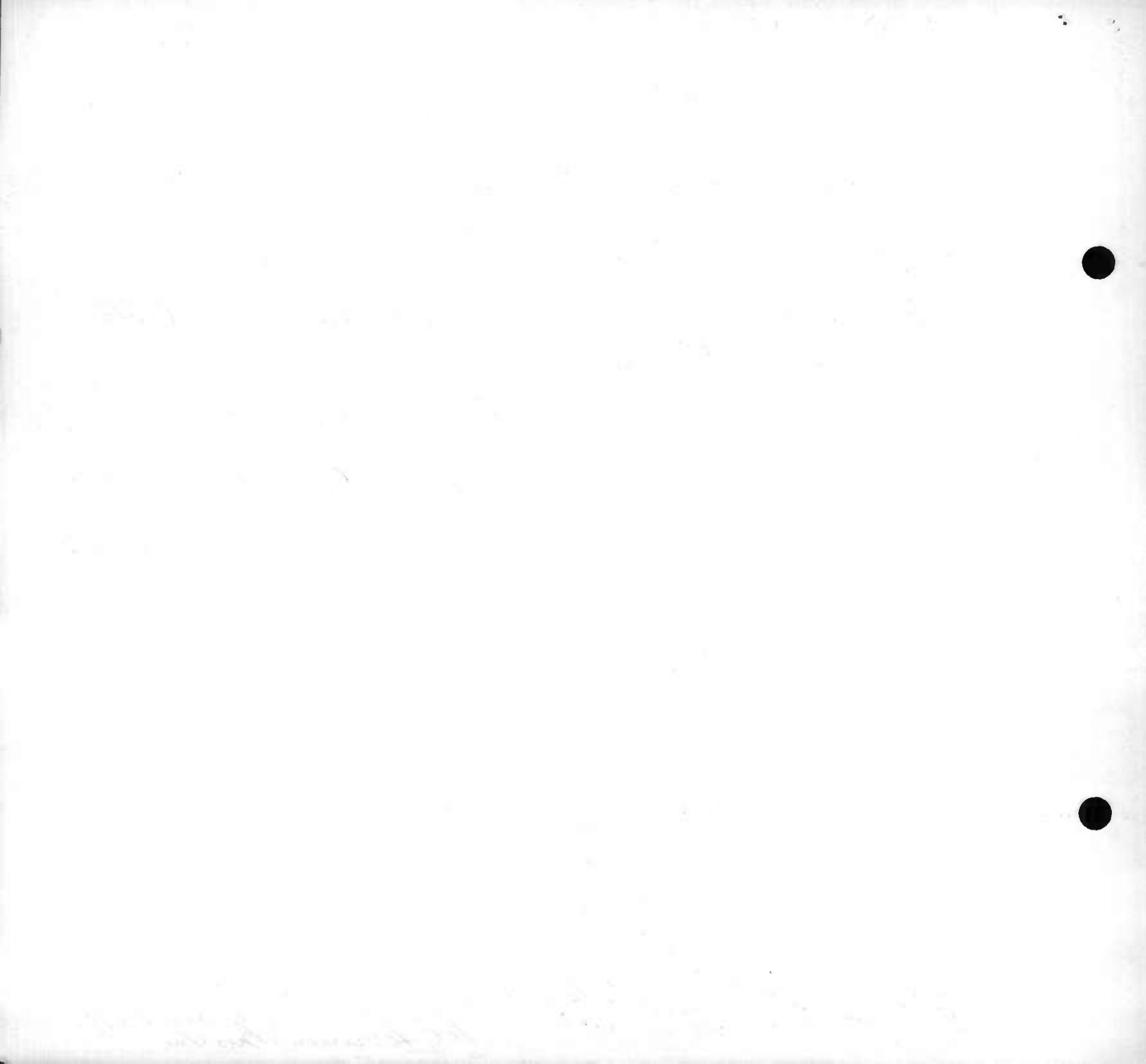
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2082</u> |
|--|--|---|--|--|
| M-600 71 2082 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>Fannie Meyer</u> | | 2. DATE AND HOUR OF DEATH <u>3/1/71</u> <u>4:45</u> <u>A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>53-00</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6950 Brookmill #15</u> | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1905</u> <u>4/10/XXX</u> | 9. AGE (In years last birthday) <u>65</u> <u>XXX</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>SIMON CHUPRECK</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>MINNIE</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | |
| 16. SOCIAL SECURITY NO. <u>214-14-9968</u> | | 17. INFORMANT <u>MR. ALEC MEYER, #6950 BROOKMILL RD., APT. 1A</u> | | |
| 18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., I means the disease, injury or complication which caused death.) <u>MI</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>MI</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute Phasic coronary inf.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Phasic CHF. Arterio-sclerotic</u> <u>Arterio-sclerotic</u> <u>Coronary atherosclerosis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>0</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (this hospital) attended the deceased from <u>2/28/71</u> 19 to <u>3/1/71</u> 19 that (we) lost saw the deceased alive on <u>3/1/71</u> 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Rup Antich</u> | | 23B. DATE SIGNED <u>3/1/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>ANTICH</u> |
| 23D. ADDRESS <u>Sinai Hospital</u> | | 23E. DEGREE | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24B. DATE <u>3-1-71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>TIFERETH ISRAEL ANSHE SFARD</u> | 24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 3 1971</u> | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u> | 25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) A physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

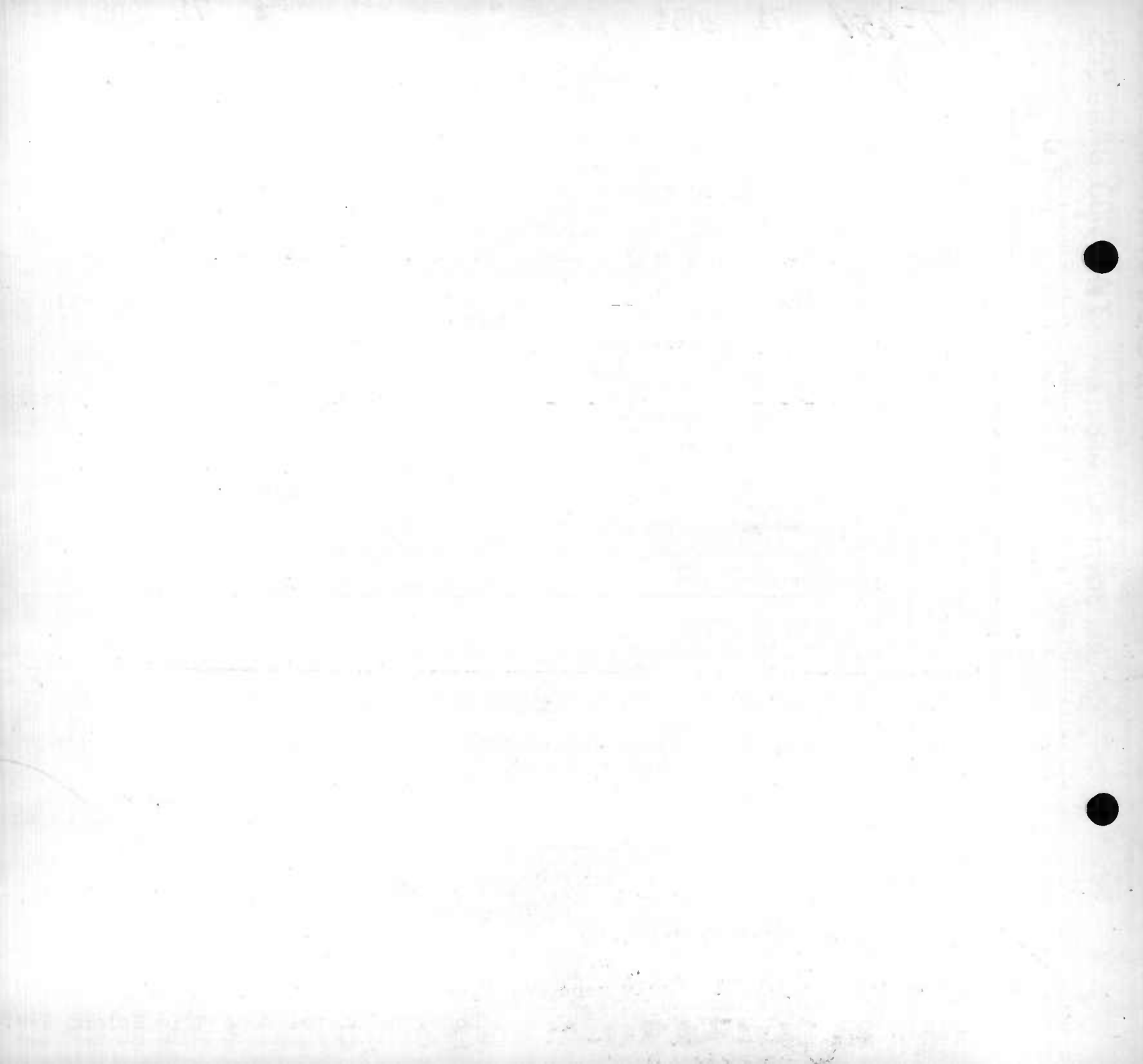
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2083</u> | |
|--|--|---|--|---|--|
| A-200 <u>71 2083</u> | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. <u>71 2083</u> | | 2. DATE AND HOUR OF DEATH <u>2-27-1971 10:20 A.M.</u> | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Sophi Ash</u> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Levendale Aged Home</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Ind</u> B. COUNTY <u>Baltimore</u> | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-5</u> 9. AGE (In years last birthday) <u>85</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Abraham Glass</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Abraham Ash - 7932 Dunhill Village</u> ADDRESS <u>pt 203</u> | |
| 18. <u>5-92 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PYELONEPHRITIS</u> | | <u>WEEKS</u> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>NEPHROLITHIASIS</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>YEARS</u> | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that xx (this hospital) attended the deceased from <u>December</u> 19 <u>70</u> to <u>2-27</u> 19 <u>71</u> that <u>U</u> (we) last saw the deceased alive on <u>2-27</u> 19 <u>71</u> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. <u>U</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Theodore R. Reiff</u> DEGREE | | | | 23B. DATE SIGNED <u>2-28-1971</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Theodore R. Reiff, MD</u> | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/28/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>Balt., Md.</u> | | 24E. STATE <u>Md.</u> | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>MAR 3 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>16018 Bay Rd.</u> ADDRESS <u>Baltimore, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2084 | |
|--|---------------------|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> T-654 71 2084 71 2084 </div> | | | | | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Mary B. Trimilove | | | Feb 28, 1971 10:30 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Edgewood Nursing Home 6000 Bellona Avenue | | | A. STATE Maryland | | |
| | | | B. COUNTY 27-12 | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 1 Brackenridge Ct. 21212 | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jun 20, 1889 | 9. AGE (In years last birthday) 81 yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY -- | 11. BIRTHPLACE (State or foreign country) Lithuania | | 12. CITIZEN OF WHAT COUNTRY? Lithuania |
| 13. FATHER'S NAME Joseph Aleksene | | | 14. MOTHER'S MAIDEN NAME Sakawich | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --- | | 16. SOCIAL SECURITY NO. 220-54-6328 | 17. INFORMANT Mary Adams - 1 Brackenridge Ct. 21212 | | |
| 18. 41241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction, atherosclerotic vascular disease</i> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2+ yrs.</i> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 31, 1969</i> to <i>Feb 28, 1971</i> , that (I) (we) last saw the deceased alive on <i>Feb 28, 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Fredrick J. Vollmer MD</i> | | | | 23B. DATE SIGNED <i>3-1-71</i> | |
| 23C. PHYSICIAN'S NAME (Type) Fredrick Vollmer, MD | | 23D. ADDRESS 6100 York Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/4/71 | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>Philip E. Taylor, Md.</i> | | 25C. FUNERAL DIRECTOR ADDRESS Donovan Funeral Home 3818 Roland Ave. | |



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H-400

71

2085

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2085

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Joseph Hall | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 2 28 71 12:25 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 113 W. Franklin St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 28 71 12:25 p.m. | |
| 6. SEX male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 9 Feb. 1930 | | 10. AGE (In years last birthday) 41 | |
| 11. BIRTHPLACE (State or foreign country) OHIO | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME (UNOBTAINABLE) | | 14. MOTHER'S MAIDEN NAME (UNOBTAINABLE) | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEM. ENGR. | | 16. KIND OF BUSINESS OR INDUSTRY STEEL | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | 18. SOCIAL SECURITY NO. 111-11-1000 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hanging (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20A. DATE OF OPERATION 6 | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 113 W. Franklin St. 4-01 | | 22D. HOW DID INJURY OCCUR? Subject hanged himself | |
| 22E. TIME (Month) (Day) (Year) (Hour) (Approx.) ? ? ? ? | | 22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED 3/1/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 14 MAR 71 | |
| 24C. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 24D. LOCATION (City, town, or county) (State) ELYRIA TOWNSHIP, OHIO | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS ELYRIA, O. | |

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1
H-620 71 2087 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 2087

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|--|------------------|---|--|--|--------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Helen Harris | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 2 Day 28 Year 71 Hour 12:35 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1329 N. Fulton Avenue | | 3. DATE PRONOUNCED DEAD Month 2 Day 28 Year 71 Hour 12:35 p.m. | | 5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE Md. B. COUNTY | |
| 6. SEX female | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH Oct. 28, 1953 | | 10. AGE (In years last birthday) 17 | 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF U.S.A. |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 14B. KIND OF BUSINESS OR INDUSTRY | | 13. FATHER'S NAME Herman Harris | |
| 15. MOTHER'S MAIDEN NAME Mildred Brooks, | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. None | |
| 18. INFORMANT Mildred Harris | | ADDRESS 1329 N. Fulton St. | | E. STREET AND NUMBER 1329 N. Fulton Avenue 15-02 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Epilepsy | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: 3/1/71 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/4/71 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | 25B. NAME OF REGISTRAR Kenneth H. Law | |
| 25C. FUNERAL DIRECTOR Kenneth H. Law | | ADDRESS 4609 Park Heights Ave. | | | |

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AMERICAN AIRLINES

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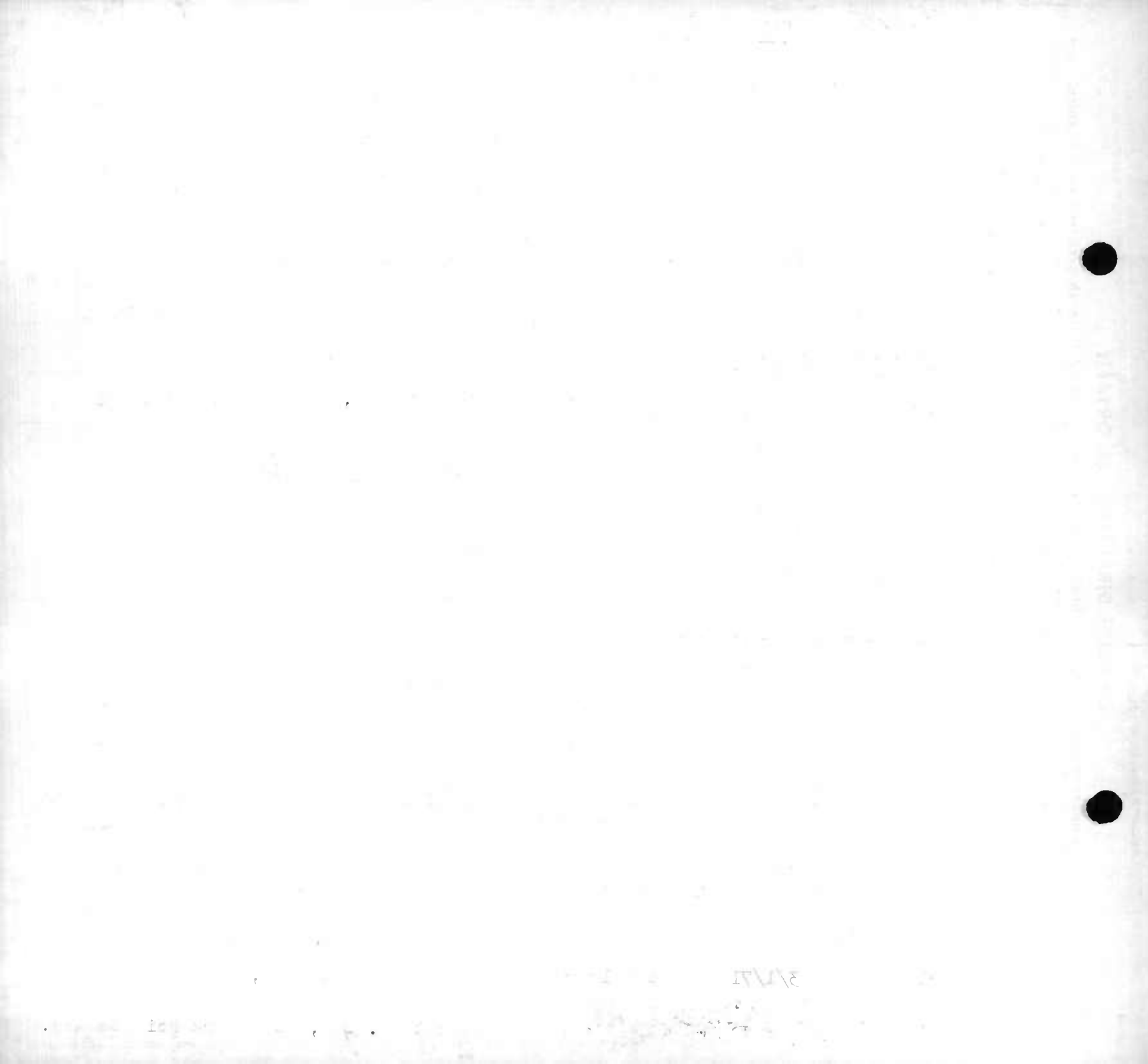
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AMERICAN AIRLINES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

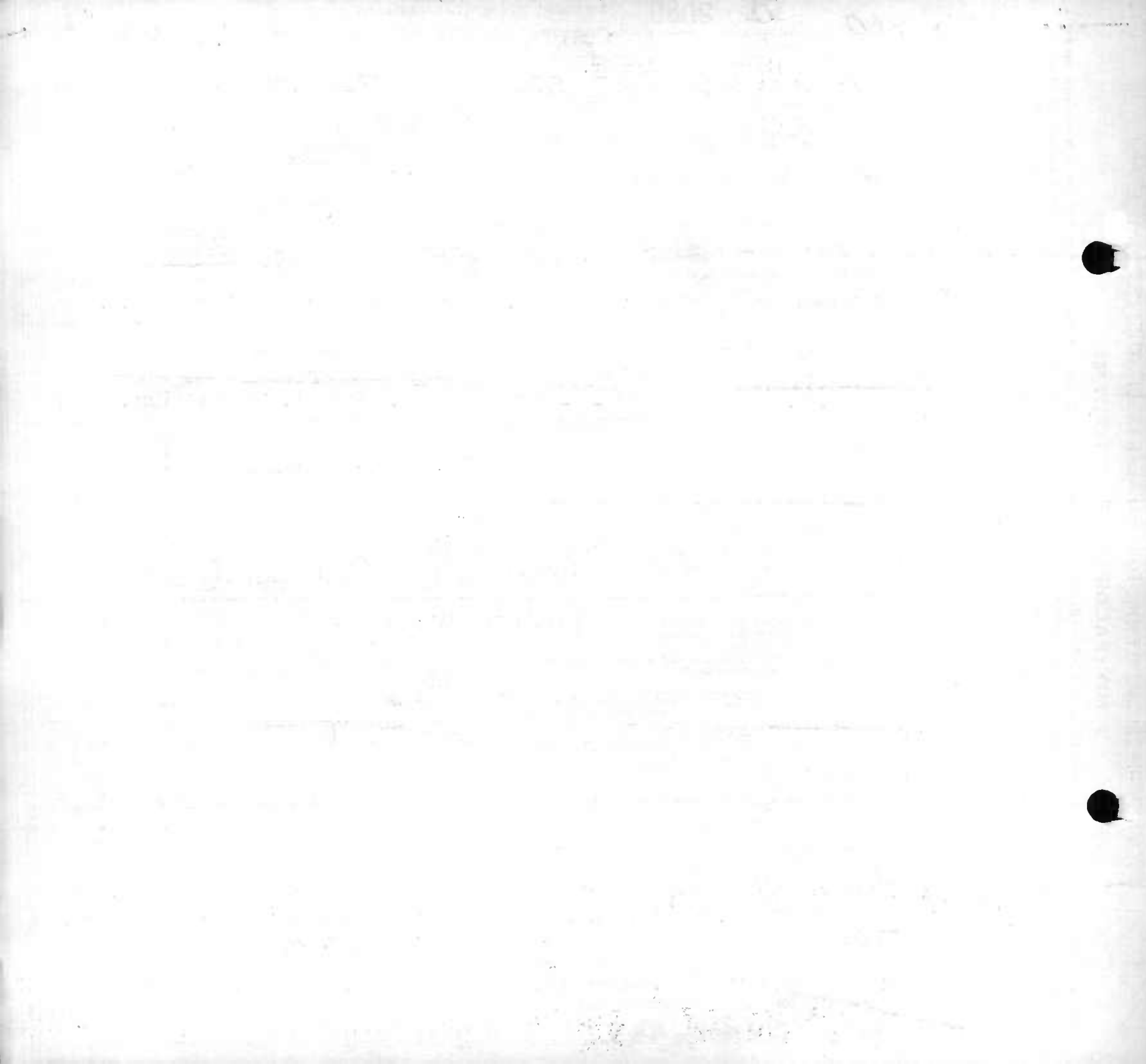
| G-615 71 2088 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2088 | |
|---|--|---|--|--|--|---|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| MAMIE M. GRIFFIN | | | | 3/24/71 @ 19:21 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL | | | | A. STATE MD. | | B. COUNTY BALTIMORE | |
| | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX FEMALE | | | | 6. RACE NEGRO | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME EDWARD LIPCOMB | | | |
| 14. MOTHER'S MAIDEN NAME RUTH CAMP | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 2 | | | | 17. INFORMANT Ruth Griffin, 1636 Mountmore Court | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary embolus (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Int/45 | |
| | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/22 19 71 to 2/24 19 71 that (I) (we) last saw the deceased alive on 2/24 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Kenneth H. Legum M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/24/71 | |
| 23C. PHYSICIAN'S NAME (Type) KENNETH H. LEGUM M.D. | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/71 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor R.H. | | 25C. FUNERAL DIRECTOR Kenneth H. Law, 4609 Park Heights Ave. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. S-460 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2088 | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Albert Lee Sklar Sr. | | | | 2. DATE AND HOUR OF DEATH FEB 27, 1971 1:40 A.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL | | | | C. CITY OR TOWN BALTIMORE | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER 2513 ORLEANS STREET 6-02 | | | | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-2-11 | | 9. AGE (In years last birthday) 59 | | 11. Under 1 Yr. Months: Days: 11 Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Technician | | | | 10B. KIND OF BUSINESS OR INDUSTRY Johns Hopkins Hosp. | | | | 11. BIRTHPLACE (State or foreign country) Martinsburg, West Virginia | | | |
| | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME David Sklar | | | | 14. MOTHER'S MAIDEN NAME Sarah Brodsky | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W. W. II | | | | 16. SOCIAL SECURITY NO. 215-03-7376 | | | | 17. INFORMANT ADDRESS Albert L. Sklar Jr. 10 Capella Ct. 21237 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ? Myocardial Infarction | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease | | | | years | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes Mellitus | | | | | | | | years | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROX. | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/27 1971 to 2/27 1971 that (I) (we) last saw the deceased alive on 2/27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Trexler M. Topping M.D. | | | | | | | | 23B. DATE SIGNED 2/27/71 | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) TREXLER M TOPPING M.D. | | | | 23D. ADDRESS Johns Hopkins Hospital, Baltimore, Md | | | | | | | |
| | | | | JOHNS HOPKINS HOSPITAL | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/3/71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Randallstown, Baltimore, Md. 21133 | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | | | 25B. NAME OF REGISTRAR Loring Byers | | | | 25C. FUNERAL DIRECTOR ADDRESS 21133 8728 Liberty Rd. Randallstown, Md | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT 71 2090 71 2090 | | | | REG. NO. 71 2090 | |
|---|------------------|---|------------------------------------|--|---|
| BIRTH NO. R-200 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Nora Rich | | 2. DATE AND HOUR OF DEATH 2/27/71 4:50 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Good Samaritan Hospital 5601 Loch Raven Boulevard | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY 10-02 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1716 E. Madison Street | | | |
| 5. SEX F | 6. RACE B | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/04/27 | 9. AGE (In years last birthday) 44 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC | | 10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | | 11. BIRTHPLACE (State or foreign country) ELIZABETH CITY - N.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME NOT KNOWN | | | |
| 14. MOTHER'S MAIDEN NAME NOT KNOWN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 239-44-5663 | | 17. INFORMANT MACQUERITE WILLIAMS ADDRESS 4314 KATHLEEN AVE | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 493 X | | CAUSE OF DEATH Cardio-Respiratory Arrest | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arrhythmia w/ Pul embolus (B) DUE TO, OR AS A CONSEQUENCE OF: EDH Cardiomyopathy + Pericarditis (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/26/71 19 71 to 2/27 19 71 that (I) (we) last saw the deceased alive on 2/26/71 4:40 PM 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rein Saral | | 23B. DATE SIGNED 2/27/71 | | 23C. PHYSICIAN'S NAME (Type) REIN SARAL | |
| 23D. ADDRESS GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | |
| 24B. DATE 3/5/71 | | 24C. NAME OF CEMETERY OR CREMATORY MT. CALVARY CEM. | | 24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL COUNTY | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR DIANORETTA BROWN ADDRESS 3106 WILBROOK AVE. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2091 | |
|---|------------------|---|----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) LEMMERMAN, John F | | 2. DATE AND HOUR OF DEATH 3-2-71 6:15 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 117 Stonewall Road | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 07/27/90 | 9. AGE (In years last birthday) 80 | 10. UNDER 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME John F Lemmerman | | 14. MOTHER'S MAIDEN NAME Augusta Eggman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. John F. Lemmerman, Sr., 117 Stonewall Rd | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Exhaustion, weakness, post-operative Post. Hepatoma. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatoma + Rectal bleeding may be Ca. metastatic of liver, source from Intestines. (B) DUE TO, OR AS A CONSEQUENCE OF: The same as above (C) Rectal bleeding gradually | | | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none | | 20A. AUTOPSY? (Yes or No) X | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none | |
| 21D. TIME OF INJURY (APPROX.) B 2 71 6:15 PM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/24 19 71 to 3/2 19 71 that (I) (we) last saw the deceased alive on 3/2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. F. Kazemi | | DEGREE | | 23B. DATE SIGNED 3/2/71 | |
| 23C. PHYSICIAN'S NAME (Type) FERDOUS KAZEMI | | DEGREE | | 23D. ADDRESS BON SECOURS HOSPITAL, Baltimore, Md 21223 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/5/71 | | 24C. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran | |
| 24D. LOCATION (City, town, or county) (State) Fulton, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | 25B. NAME OF REGISTRAR Robert E. J. [unclear] | | 25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Ave., 21228 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | CERTIFICATE OF DEATH | | REG. NO. 71 2092 | |
|--|----------------------|--|--------------------------------|--|--------------------------------|---|--|
| BIRTH NO. 5-152 71 2092 | | 1. NAME OF DECEASED (Type or Print) <u>MARY SPENCER</u> | | 2. DATE AND HOUR OF DEATH <u>3/1/71</u> <u>7:00 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>1114 McDONALD ST</u> | | | | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/1/05</u> | 9. AGE (In years last birthday) <u>65</u> | 10. If Under 1 Yr. Months Days | 11. If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Alabama</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Harry Mitchell</u> | | 14. MOTHER'S MAIDEN NAME <u>Kelly Beaumont</u> | | 15. Was deceased in U.S. Armed Forces? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>James Hefat Samie</u> | | ADDRESS | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> 3 hours | | | |
| ANTECEDENT CAUSES | | | | (B) CORONARY ART DISEASE UNKNOWN | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/1/71</u> 19 <u>71</u> to <u>3/1/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/1/71</u> 19 <u>71</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Robert A. Vigersky, M.D.</u> | | | | 23B. DATE SIGNED <u>3/1/71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS <u>Johns Hopkins Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>3-6-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Court</u> | | 24D. LOCATION (City, town, or county) (State) <u>MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8, 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Vigersky, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Robert E. Vigersky, M.D.</u> | | ADDRESS | |

Henry M. Hill
to

William
Hilly Crescent
James West Lane

James West Lane
Hilly Crescent
to

H-20071

2093

BALTIMORE CITY HEALTH DEPARTMENT

71

2093

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|-------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) IVRA HAWES | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year Hour February 28, 1971 1:00 A.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| 6. SEX Male | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH Oct 14 - 1917 | | 10. AGE (In years last birthday) 53 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTH PLACE (State or foreign country) Sumner Ga. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Leon Hawes | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME Offie | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes | |
| 17. SOCIAL SECURITY NO. 242-20-3198 | | 18. INFORMANT Catharine E Hawes ADDRESS same | |
| 19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 2/28/71 DATE SIGNED | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Catharine | | 24D. LOCATION (City, town, or county) (State) Catharine Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | 25B. NAME OF REGISTRAR Robert J. Smith | |
| 25C. FUNERAL DIRECTOR Robert J. Smith | | 25D. ADDRESS 1000 Broadway St | |

Chas. J. Fox

for

1114 1000 House

Upper

200000 100000 House

2000 2000 100000

100000 100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| T-656 71 2094 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2094 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Turner Charles</u> | | 2. DATE AND HOUR OF DEATH <u>2/27/71 7:10 PM</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nursing Home</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>906 Edmondson Ave.</u> | | 5. SEX <u>M</u> | | 6. RACE <u>Black</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/25/11</u> | | 9. AGE (In years last birthday) <u>59</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY | | 13. FATHER'S NAME <u>Abraham Turner</u> | | 14. MOTHER'S MAIDEN NAME <u>Mamie</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Y</u> | | 16. SOCIAL SECURITY NO. <u>218-10-000</u> | | 17. INFORMANT <u>Information Trust</u> | |
| 18. <u>303.21</u> CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>years</u> <u>years</u> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> 19 <u>71</u> to <u>2/27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>2/27</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | 23B. DATE SIGNED <u>2/28/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MUEHT MD</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-3-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Interfaithway Cmt</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Chesapeake County Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 3 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u> | |
| 25C. FUNERAL DIRECTOR <u>[Signature]</u> | | 25D. ADDRESS <u>1077 Chesapeake Ave</u> | | | |

Page 2-20 of 20
Date: 10/10/2010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2095

BIRTH NO.

| | | | | | |
|---|-------------------------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) WILLIAM H. DOWNEY | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> 2-24-71 | | Month Day Year Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2416 Liberty Heights | | 3. DATE PRONOUNCED DEAD Month Day Year Hour February 24, 1971 9:15 P.M. | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY | |
| 6. SEX Male | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH Oct 16 - 1875 | | 10. AGE (In years lost birthday) 95 | | E. STREET AND NUMBER 2416 Liberty Heights 15-05 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME William Downey | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Laura Davis | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give War or dates of service) No | | 17. SOCIAL SECURITY NO. 213-09-7497 | | 18. INFORMANT Laura Kent 57. Benton St | |
| 19. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) No | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: February 25, 1971 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-1-71 | | 24C. NAME OF CEMETERY or CREMATORY MT HUBURN | |
| 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | | |
| 25B. NAME OF REGISTRAR Debra E. Johnson | | 25C. FUNERAL DIRECTOR ELROY O. WILSON | | 25D. ADDRESS 1000 BRANTLEY AVE | |

1

6-420 71 2096 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2096

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) LEONARD GILES | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 25 1971 12:15 P.M. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH June 16 - 1923 | | 10. AGE (In years last birthday) 48 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES | | 17. SOCIAL SECURITY NO. 215-167367 | |
| 13. FATHER'S NAME Andrew Giles | | 15. MOTHER'S MAIDEN NAME Alice Giles | |
| 18. INFORMANT Pauline Giles | | ADDRESS Same | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: multiple injuries | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. multiple injuries | | (B) DUE TO, OR AS A CONSEQUENCE OF: multiple injuries | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street | |
| 22D. TIME (Month) (Day) (Year) (Hour) 2-8-71 a | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Harford & Bonaparte | | 22F. HOW DID INJURY OCCUR? Driver of car which hit a building. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. | | DATE SIGNED 2-26-71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Buried | | 24B. DATE 3-2-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cat | | 24D. LOCATION (City, town, or county) (State) Baltimore md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3, 1971 | | 25B. NAME OF REGISTRAR Robert E. J. Barber, M.D. | |
| 25C. FUNERAL DIRECTOR Gray O. Wilson | | ADDRESS Baltimore md | |

VS 151-REV. 1/1/68

Wm. H. H. H. H.
H. H. H. H. H. H.

Wm. H. H. H. H.

Wm. H. H. H. H. H. H.
H. H. H. H. H. H. H.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2097

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary Brown Parker

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month
2Day
28Year
71Hour
6:27p.

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

3. DATE
PRONOUNCED DEADMonth
2Day
28Year
71Hour
6:27

P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Md.

B. COUNTY

6. SEX

female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Oct 21-1946

10. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

710 E. Biddle Street 10-01

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Parker

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ora Samuel

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

William Parker

ADDRESS

Same

19. E9651X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Gunshot wound of head

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

HOME

22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?

710 E. Biddle Street 1001

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

2

28

71

?

22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject was shot in the head by husband

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Peter Lipkovic, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3/1/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-5-71

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Balto

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 3 1971

25B. NAME OF REGISTRAR

Charles E. Jones, M.D.

25C. FUNERAL DIRECTOR

Connelley

ADDRESS

1000 Broadway St

Oct 21-1944
John (Lindbergh)
Jenny
76

1944

William (Lindbergh)
Oscar
William (Lindbergh)

RECEIVED
OCT 21 1944
U.S. AIR FORCE

Annual 2-11-1944
Lindbergh

B-650

71 2098

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2098

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) EMMITT BROWN | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year February 24, 1971 Hour M. 6:05 P. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 1051 N. Broadway | | 3. DATE PRONOUNCED DEAD Month Day Year February 24, 1971 Hour M. 6:05 P. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH Oct 24-1920 | | 10. AGE (In years last birthday) 48 | |
| 11. BIRTHPLACE (State or foreign country) Michigan | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME Janne Randall | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 325-24-6575 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Epilepsy DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 18. INFORMANT ADDRESS Wilma Brown | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No) No | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: February 25, 1971 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-1-71 | |
| 24C. NAME OF CEMETERY or CREMATORY MT CALVARY | | 24D. LOCATION (City, town, or county) (State) ARUNDEL Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR E. Roy O. Wilson | | 25D. ADDRESS 1600 BRANTLEY AVE | |

ACADEMIC MODEL

Virginia
Cotton

1914
James P. Smith
James P. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| C-420 | | 71 2099 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 71 2099 | |
|---|---------------------|--|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) JOHN HILL COLES | | | | 2. DATE AND HOUR OF DEATH 3-2-71 13:30 A.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. CITY BALTIMORE | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER 1334 W. NORTH AVE. 13-03 | | | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-27-20 | 9. AGE (In years lost birthday) 50 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION | | | | 10B. KIND OF BUSINESS OR INDUSTRY LABOR INTERNATIONAL UNION | | 11. BIRTHPLACE (State or foreign country) South Hill, Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME unknown | | | | 14. MOTHER'S MAIDEN NAME Lucy Coles | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 229-18-3389 | | 17. INFORMANT F. R. REARD | | ADDRESS | |
| 18. 4330 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cerebral Infarction Lt. Hemisphere with Sudden Onset (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension, peripheral | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Bilateral Pulmonary embolism & Bronchopneumonia | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-26 19 71 to 3-2 19 71 that (I) (we) last saw the deceased alive on 3-2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Michael Grasso M.D. | | | | DEGREE MD | | 23B. DATE SIGNED 3-2-71 | | | |
| 23C. PHYSICIAN'S NAME (Type) MICHAEL GRASSO MD. | | | | 23D. ADDRESS MARYLAND GENERAL HOSP. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY Sunset Cem. | | 24D. LOCATION (City, town, or county) (State) Palmyra, New Jersey | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR Alfred A. Piller | | ADDRESS 1727 N. Howard St. | | | |

200-20
Bentley's
Lucky Charm

200-20

200-20
Bentley's

200-20 Bentley's

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2100</u> | |
|---|------------------------------|---|--|--|--|
| BIRTH NO. <u>71 2100</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Hamilton, Mr. Edward E.</u> | | 2. DATE AND HOUR OF DEATH <u>3-2-71</u> <u>9¹⁰ PM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Keswick Home</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-02</u> | | | |
| | | C. CITY OR TOWN <u>Baltimore, Md.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>1 EAST University Pkway</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-1-1879</u> | 9. AGE (In years last birthday) <u>91 years</u> | 10. Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comptroller RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>F.A. DAVIS & SON</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u> | |
| 13. FATHER'S NAME <u>James E. Hamilton</u> | | 14. MOTHER'S MAIDEN NAME <u>Caroline Herbst</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>701-10-6689</u> | | 17. INFORMANT <u>Keswick Records</u> | |
| | | | | ADDRESS <u>700 W 40th ST</u> | |
| 18. <u>712.3</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>12 yrs.</u> |
| | | | (B) <u>ASHD Ch. MI + RBBB</u> DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) <u>Glucose + macular Degeneration</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>December 17 1970</u> to <u>MARCH 2 - 1971</u> that (I) (we) last saw the deceased alive on <u>MARCH 2 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>E. Hunter Wilson, Jr.</u> | | DEGREE | | 23B. DATE SIGNED <u>3-3-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>E. Hunter Wilson, Jr. M.D.</u> | | 23D. ADDRESS <u>Keswick Home</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>3-5-1971</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 3 1971</u> | | 25B. NAME OF REGISTRAR <u>John E. Jaber, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Henry W. Jenkins & Sons Co.</u> | |
| | | | | ADDRESS <u>1908 York Road Balto., Md. 21212</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

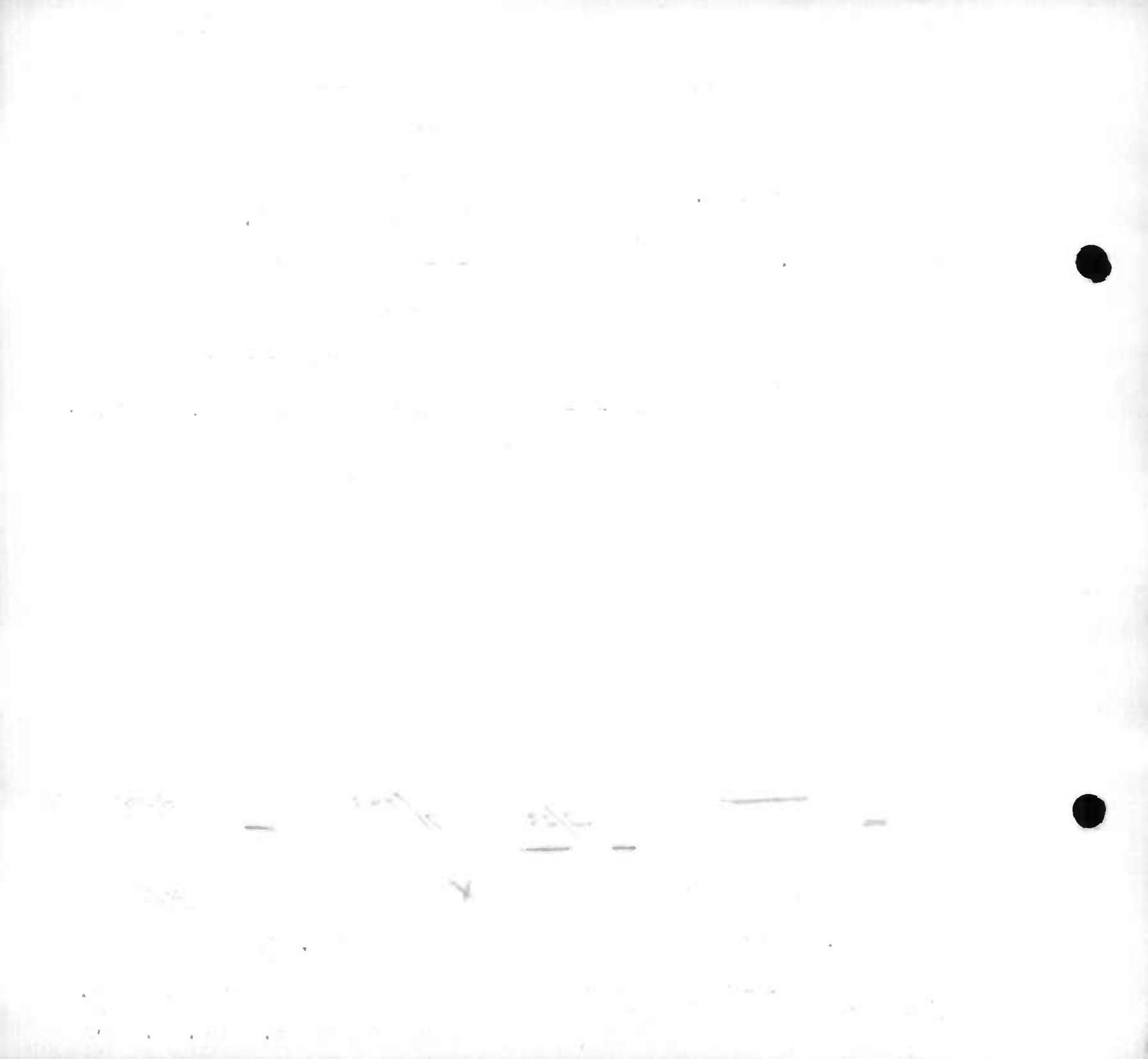
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 2101</u> | |
|---|------------------|---|--|---|---|--|--|
| BIRTH NO. <u>71 2101</u> | | 1. NAME OF DECEASED (Type or Print) <u>William A. Snyder</u> | | 2. DATE AND HOUR OF DEATH <u>2/28/71</u> <u>3:50</u> P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>136 S. Schroeder St.</u> <u>18-03</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/22/03</u> | 9. AGE (In years last birthday) <u>67</u> | 10. If Under 1 Yr. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>railroad worker</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ky.</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>James Snyder</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>Anna Rader</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u> | | | | |
| 16. SOCIAL SECURITY NO. <u>302-03-48</u> | | | 17. INFORMATION ADDRESS <u>Son & wife 136 S Schroeder St.</u> | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory Arrest</u> (B) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u> (C) <u>Kidney tumor</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No.</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> 19 <u>71</u> to <u>2/28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3:50 PM</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Stephen Greenberg</u> | | | | 23B. DATE SIGNED <u>2/28/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Stephen Greenberg</u> | |
| 23D. ADDRESS <u>George A. Schwab</u> | | | | 23E. CITY <u>2101 Fredrick Ave</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>March 4-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 3 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jaber, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>George A. Schwab</u> | | 25D. ADDRESS <u>2101 Fredrick Ave</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

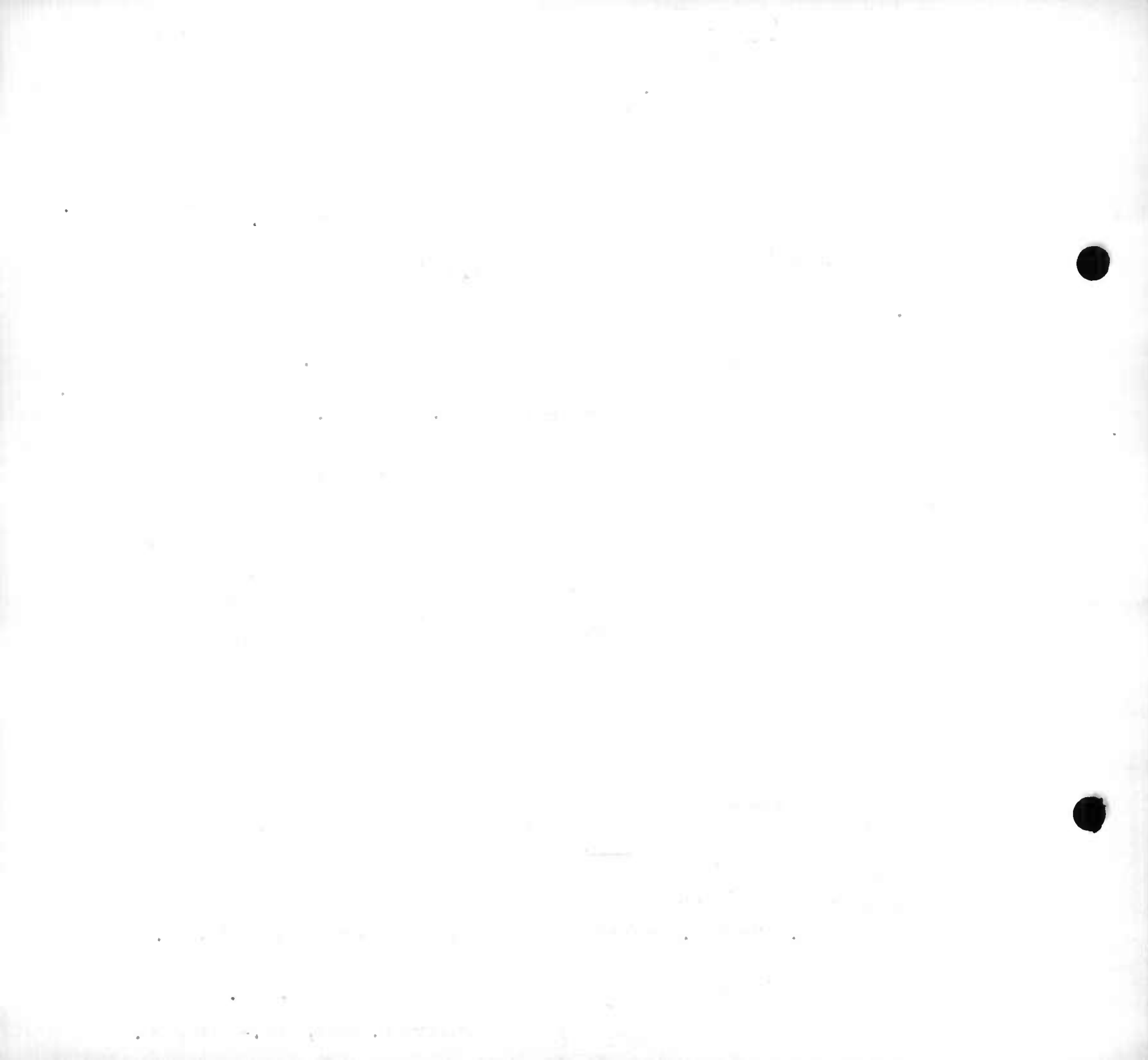
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2102 | |
|---|--|---|---|---|--|
| BIRTH NO. S-363 | | 71 2102 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Jacob R Streett | | | 2. DATE AND HOUR OF DEATH 3-1-71 9A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1711 North Chapel St. | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1711 North Chapel St. | | |
| 5. SEX Male 6. RACE Cauc. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9-30-10 9. AGE (In years last birthday) 60 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 10B. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Gailey Streett 14. MOTHER'S MAIDEN NAME Mary Catherine Morrison 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 213-07-1583 17. INFORMANT Mrs Gladys E Streett 1711 N. Chapel St. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Carcinoma of left lung with generalized metastasis</i> (A) IMMEDIATE CAUSE <i>with generalized metastasis</i> DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 3/28/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS CONTRIBUTING OR CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 3/28/1971 to 3/28/1971 that (I) (we) last saw the deceased alive on 3/23/1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <i>[Signature]</i> DEGREE 23B. DATE SIGNED 3/28/71 23C. PHYSICIAN'S NAME (Type) M. Friedman 23D. ADDRESS 5211 Harford Rd. 21214 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3-4-71 24C. NAME of CEMETERY or CREMATORY Belair Memorial Gardens 24D. LOCATION (City, town, or county) (State) Belair Harford Md. | | 25. FUNERAL DIRECTOR Leonard J Rack Inc. Balto. Md. 21214 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| C-425 71 2103 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2103 | |
|--|----------------------|---|-------------------------------|---|---|
| BIRTH NO. | | REG. NO. | | 71 2103 | |
| 1. NAME OF DECEASED (Type or Print) | | PETER M. CALZONE | | 2. DATE AND HOUR OF DEATH March 1, 1971 11 40 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland | | B. COUNTY 53-00 | |
| HOUSE IN THE PINES BELAIRE | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 3051X Pinewood Ave. | | 6910 Willowdale Ave. | |
| 5. SEX male | 6. RACE caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/29/1894 | 9. AGE (in years last birthday) 76 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Machinist | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Frank Calzone | | 14. MOTHER'S MAIDEN NAME Mary A. Nero | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 213-03-6428 | | 17. INFORMANT Mrs. Ellen V. Barber 6910 Willowdale Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Peripheral Circulatory Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Toxic Myocarditis DUE TO, OR AS A CONSEQUENCE OF: (C) Uremia / Diabetic Nephropathy Peripheral Nerve Lesions; Urinary Tract Infection; Diabetes; Parkinson's Disease; Old Stroke; Hypertension | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day days weeks years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/19/71 to 3/1/71 that (I) lost saw the deceased alive on 3/1/71 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert B. Bradley | | 23B. DATE SIGNED 3/2/71 | | 23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley | |
| 23D. ADDRESS 4900 Belair Road, Balto, Md. | | 23E. NAME OF REGISTRAR | | 23F. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/5/71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 24E. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 24F. NAME OF REGISTRAR Robert E. Taylor | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2104 | |
| BIRTH NO. J-252 | | 71 2104 CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) JAZ WINSKI Mrs. Josephine | | 2. DATE AND HOUR OF DEATH 3.2.1971 6.10 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 100 N Broadway Baltimore MD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 53-00 | |
| 5. SEX Female 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 8. DATE OF BIRTH 4.23.1900 9. AGE (In years last birthday) 70 | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) POLAND | |
| 13. FATHER'S NAME FELIX BARANOWSKI | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT PETER JAZWINSKI | | ADDRESS 7289 BRIDGEWOOD DR | |
| 18. 712.31 | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe Rheumatoid arthritis | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis | |
| | | (C) ASHD | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years | |
| 19A. DATE OF OPERATION 712.31 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (t) (this hospital) attended the deceased from 2.26.1971 to 3.2.1971 that (p) (we) lost saw the deceased alive on 3.2.1971 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (t) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Abdus Samad. | | 23B. DATE SIGNED 3.2.1971 | |
| 23C. PHYSICIAN'S NAME (Type) ABDUS SAMAD MD | | 23D. ADDRESS MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/5/71 | |
| 24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY | | 24D. LOCATION (City, town, or county) (State) DUNDALK MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1971 | | 25B. NAME OF REGISTRAR Robert E. Fabian | |
| 25C. FUNERAL DIRECTOR JOHN WIEBER | | ADDRESS 401 S. CHESTER ST. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2105</u> | |
|--|--|--|--|---|--|
| J-250 | | 71 2105 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>LARRY ANDREW JACKSON</u> | | 2. DATE AND HOUR OF DEATH <u>3/1/71</u> <u>8</u> <u>45</u> <u>P</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY | | C. CITY OR TOWN <u>BALTIMORE</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIV. OF MARYLAND HOSPITAL</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>M</u> | | 6. RACE <u>N</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>10/21/50</u> | | 9. AGE (In years last birthday) <u>20</u> | | 10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u> | |
| 13. FATHER'S NAME <u>MATHALO JACKSON</u> | | 14. MOTHER'S MAIDEN NAME <u>JOSEPHINE WARREN</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Josephine Jackson 22191 Fremont Ave</u> | |
| 18. <u>135-X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Upper respiratory tract obstruction</u> (B) <u>Sarcoidosis</u> (C) <u>—</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Secondary Cushing's Disease</u> | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-1-71</u> 19 <u>71</u> to <u>3-1</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>3-1</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Jaime F. Casellas</u> | | 23B. DATE SIGNED <u>3-1-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>JAIME F. CASELLAS</u> | |
| 23D. ADDRESS <u>UNIVERSITY HOSPITAL</u> | | 23E. DEGREE | | 23F. NAME OF CEMETERY OR CREMATORY <u>Elizabeth Bapt. Chr. Com. D.C.</u> | |
| 24A. DATE OF CREMATION, REMOVAL (Specify) | | 24B. DATE <u>3/4/71</u> | | 24C. LOCATION (City, town, or county) (State) <u>N.C.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 3 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Williams Funeral Home 3198 N. Broadway</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

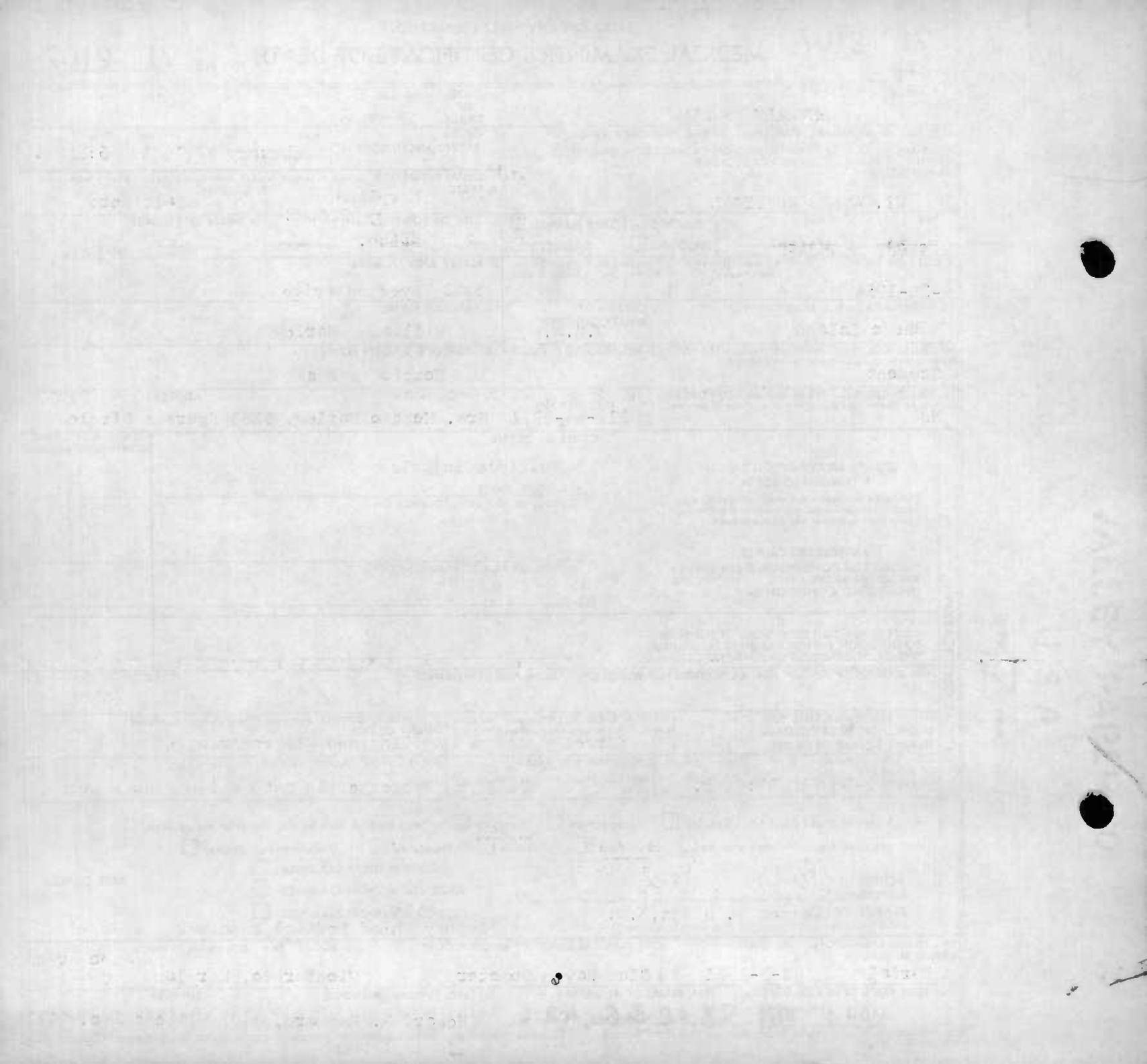
| BIRTH NO. 71 2106 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | X | | REG. NO. 71 2106 | |
|--|--|---|--|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Sullivan, Charles E.</i> | | | | 2. DATE AND HOUR OF DEATH <i>Feb. 24, 1971 6:30 p.m.</i> | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Westminster</i> | | | | 5. CITY OR TOWN <i>Westminster</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hosp.</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33rd and Calvert Sts.</i> | | | | E. STREET AND NUMBER <i>511 E. Maine</i> | | | | | | | |
| 5. SEX <i>Male</i> | | 6. RACE <i>Caucasian</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>3-10-04</i> | | 9. AGE (in years last birthday) <i>66</i> | | 10. Under 1 To 11 Under 24 Hrs. Min. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired from Congoleum-Nairn Co.</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Henry Sullivan</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Carrie Feester</i> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>218-10-0908</i> | | 17. INFORMANT <i>Miss. Carrie A. Sullivan Westminster, Md.</i> | | | | ADDRESS | |
| 18. <i>441.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>cardiac arrest</i> (B) <i>abdominal aortic aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Aortic sclerotic heart disease</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>Feb. 20, 1971</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>aortic aneurysm</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 20</i> 19 <i>71</i> to <i>Feb. 24</i> 19 <i>71</i> that (I) (we) lost saw the deceased alive on <i>Feb. 24</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>R. C. ...</i> | | | | 23B. DATE SIGNED <i>Feb. 24, 1971</i> | | | | 23C. PHYSICIAN'S NAME (Type) <i>R. C. ...</i> | | | |
| 23D. ADDRESS <i>...</i> | | | | 23E. DEGREE <i>...</i> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Feb. 27, 71</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Finksburg Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Finksburg, Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 4 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher, Jr.</i> | | 25C. FUNERAL DIRECTOR <i>J. F. Eline & Sons</i> | | 25D. ADDRESS <i>Reisterstown, Md.</i> | | | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | | | | | |
|--|-------------------------|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) BEVERLY NARLOW | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year | | 3. DATE PRONOUNCED DEAD Month Day Year February 27, 1971 | | Hour 6:55 P. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN LANS DOWNE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX Female | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER 3283 Ryerson Drive | | | |
| 9. DATE OF BIRTH 9-26-1954 | | 10. AGE (In years last birthday) 16 | | 11. BIRTHPLACE (State or foreign country) Rhode Island | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Narlow | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 15. MOTHER'S MAIDEN NAME Nettie Rusk | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 217-64-6771 | | 18. INFORMANT Mrs. Nettie Narlow, 3283 Ryerson Circle | | ADDRESS 21227 | |
| 19. CAUSE OF DEATH Multiple Injuries DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 2-26-71 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rolling and Wilken Avenues | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 2-26-71 11:14 P. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Passenger in auto which struck tree | | | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 2/28/71 ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-1971 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland Anne Arundel County | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|---|------------------|---|-------------------------------|--|---|
| 71 2108 | | CERTIFICATE OF DEATH | | 71 2108 | |
| 1. NAME OF DECEASED (Type or Print) | | ERNST J. F. HOFFMAN, JR. | | 2. DATE AND HOUR OF DEATH February 27, 1971 10:28 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | Maryland Baltimore 5300 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 43 South Baltimore General Hospital Baltimore, Maryland | | Baltimore | | | |
| E. STREET AND NUMBER | | 4412 Norfen Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-11-1949 | 9. AGE (In years last birthday) 22 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | U.S.A. | | | |
| 13. FATHER'S NAME Ernst J.F. Hoffman, Sr. | | 14. MOTHER'S MAIDEN NAME Delores Vonordeck | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS 21227 Mr. Ernst J.F. Hoffman, Sr. 4412 Norfen Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 74391 STATUS EPILEPTICUS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC BRAIN DISEASE CONGENITAL (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II NONE | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-28-71 to 2-27-71 that (I) (we) last saw the deceased alive on 2-3-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Leon Ashman | | 23B. DATE SIGNED 3-1-71 | | 23C. PHYSICIAN'S NAME (Type) Leon Ashman | |
| 23D. ADDRESS 5907 Gwynn Oak Avenue, Baltimore, Md. | | 23E. DATE SIGNED 3-1-71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave, 21229 | |

CHRONIC BRAIN DISEASE
STATUS EPILEPTICUS
?

FUNERAL DIRECTOR: IMPORTANT

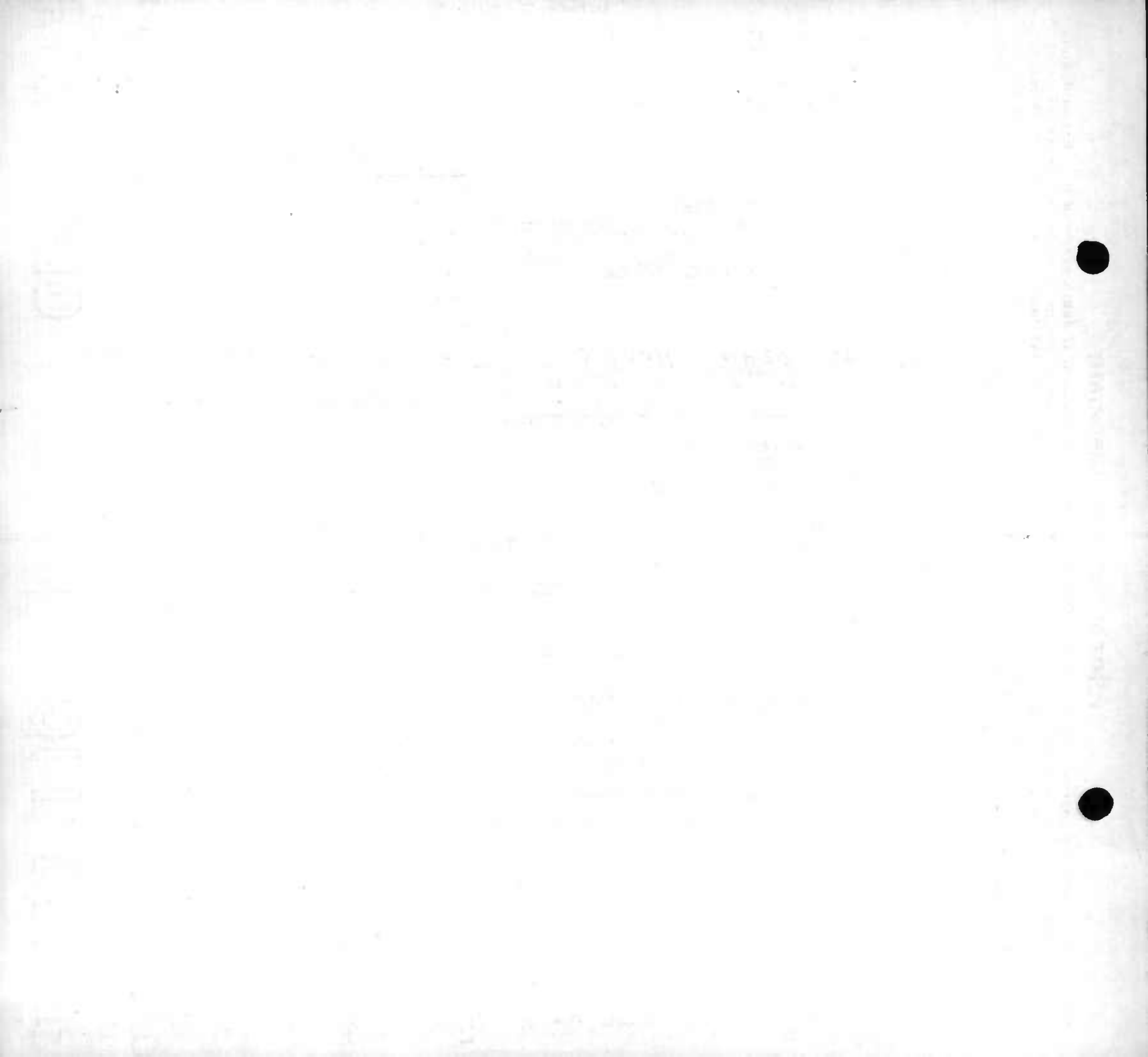
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 2109

| | | | |
|--|---------------|---|---|
| BIRTH NO. 71 2109 71-02862 | | 2. DATE AND HOUR OF DEATH 3/1/71 3:40 A.M. | |
| 1. NAME OF DECEASED (Type or Print) Thomas D. Houck | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO 5300 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital | | C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 335 Montrose Av. #21221 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/21/71 |
| 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | 11. BIRTHPLACE (State or foreign country) Maryland |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME THOMAS DEAN HOUCK | | 14. MOTHER'S MAIDEN NAME PATRICIA TOWNSEND | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT PARENTS | | ADDRESS ABOVE | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest | | | |
| (B) Possible CNS bleed DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) Prematurity | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/21 1971 to 3/1 1971 that (I) (we) last saw the deceased alive on 3/1 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE J. Eufemio M.D. | | 23B. DATE SIGNED 3/1/71 | |
| 23C. PHYSICIAN'S NAME (Type) J. EUFEMIO M.D. | | 23D. ADDRESS Mercy Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/2/71 | |
| 24C. NAME OF CEMETERY or CREMATORY BELAIR MEM. GARDEN | | 24D. LOCATION (City, town, or county) (State) BELAIR MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR J. E. CAMPBELL | |
| 25C. FUNERAL DIRECTOR J. E. CAMPBELL | | ADDRESS 300 MALE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X REG. NO. 71-2110 | |
|---|-----------|---|--|--|--|
| BIRTH NO. 71 2110 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) THADDEUS Theodore L. Malecki | | 2. DATE AND HOUR OF DEATH 2/27/71 11030 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) U.S. PHS Hospital 3-11-71 | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY AAC. 5200 | | | |
| | | C. CITY OR TOWN Linthicum | | D. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER 24 Mansion Rd. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/18/18 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Proct. + Gamble | | 9. AGE (In years last birthday) 52 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Walter Malecki | | 14. MOTHER'S MAIDEN NAME Cecilia Brooks | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1943-1945 | |
| 16. SOCIAL SECURITY NO. 212 03 1799 | | 17. INFORMANT Josephine Malecki | | ADDRESS Same #13 | |
| 18. 1929 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Emboli | | hours | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: Astrocytoma | | 1 yr. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Pneumonia | | days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Roger Little, MD | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/28/71 | |
| 23C. PHYSICIAN'S NAME (Type) R Roger Little MD | | 23D. ADDRESS U.S. PHS Hosp., Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/3/71 | | 24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery | |
| 24D. LOCATION (City, town, or County) Brooklyr PHS Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Singleton Funeral Home, Cockeysville Md. | | | |

V.S. 153

3-11-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71-2111

BIRTH NO. 71 2111

1. NAME OF DECEASED (Type or Print) Myron Livingston Hoch

2. DATE AND HOUR OF DEATH
Feb. 28, 1971 12:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
University of Maryland Hospital

C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☐ NO ☒

E. STREET AND NUMBER 3740 Oak Avenue

5. SEX Male 6. RACE White

7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH May 16, 1911 9. AGE (In years last birthday) 59
If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman

10B. KIND OF BUSINESS OR INDUSTRY
Durst Ind

11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Phillip Hoch

14. MOTHER'S MAIDEN NAME Weiss

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO

16. SOCIAL SECURITY NO. 41-121-121

17. INFORMANT ADDRESS
Hospital Admission Record

18. 202.21 CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
peritonitis and renal failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
ileal perforation of malignant ulcer
(B) DUE TO, OR AS A CONSEQUENCE OF:
malignant reticul. endotheliosis
(C) chronic cholecystitis hemorrhoids
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 1/30/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated bowel 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-27-1971 to 2-28-1971 that (I) (we) last saw the deceased alive on 2-28-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Joseph Lowe M.D. DEGREE Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED 2-28-71

23C. PHYSICIAN'S NAME (Type) JOSEPH LOWE M.D. DEGREE 23D. ADDRESS University of Md. Hospital Baltimore, Md. 21201.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3/2/71 24C. NAME OF CEMETERY OR CREMATORY Union Field Cemetery 24D. LOCATION (City, town, or county) (State) Queens New York

25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 25B. NAME OF REGISTRAR Robert E. Fisher, MD 25C. FUNERAL DIRECTOR Robert E. Fisher, MD ADDRESS 9616 Bristow Rd



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|-----------------------------------|--|---|--|------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 71 2112 | | | | | | | | | |
| BIRTH NO. 9431 | | 1. NAME OF DECEASED (Type or Print) 71 2112 <i>Malva Goldfeder</i> | | | | 2. DATE AND HOUR OF DEATH <i>2/28/71</i> 8:00 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Shai Hospital</i> | | | | | A. STATE <i>MD</i> B. COUNTY <i>2740</i> | | | | |
| CITY OR TOWN <i>Baltimore Md</i> | | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| E. STREET AND NUMBER <i>5915 Blad Ave</i> | | | | | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11/5/70</i> | 9. AGE (In years last birthday) <i>32</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i> | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <i>Gerald Goldfeder</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Sara</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Jerome Finerman #D</i> | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH <i>Cris Death</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| ANTECEDENT CAUSES | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 2-12-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Jerome Finerman</i> | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED <i>2/28/71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Jerome Finerman</i> | | | | | 23D. ADDRESS <i>3930 W. Northern Pkwy</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>2/28/71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>National Capital Hebrew</i> | | 24D. LOCATION (City, town, or county) <i>Wash Dc</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 4 1971</i> | | 25B. NAME OF REGISTRAR <i>Valerie E. Taylor, M.D.</i> | | | 25C. FUNERAL DIRECTOR <i>Sylvan Levinson Garrison, Md</i> | | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2113 | |
|---|---------------------|---|--|---|--|
| M24071 2113 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Rita McCall | | 2. DATE AND HOUR OF DEATH 2-21-71 10:35 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1538 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 2601 Roslyn Ave. Baltimore, Md 21216 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BAITo. | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 2601 ROSLYN AVE. | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 4, 1884 | 9. AGE (In years lost birthday) 86 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BAITo. MD. | |
| 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MR. WILSON - 2601 Roslyn Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 412.4 | | CAUSE OF DEATH Arteriosclerotic Cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Undetermined | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). none | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAR 1 19 69 to Feb. 21 19 71 , that (I) lost saw the deceased alive on Feb. 11 19 71 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death. | | | | | |
| 23A. SIGNATURE Robt. B. Wright | | | | 23B. DATE SIGNED 2-22-71 | |
| 23C. PHYSICIAN'S NAME (Type) Robt. B. Wright | | | | 23D. ADDRESS Med. Arts Bldg. Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3/1/71 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | |
| 24D. LOCATION (City, town, or county) (State) Old Frederick Road Baltimore | | 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Kramer Funeral Home 1216 S. Clay St | | | |

2001 10/10/01

10/10/01

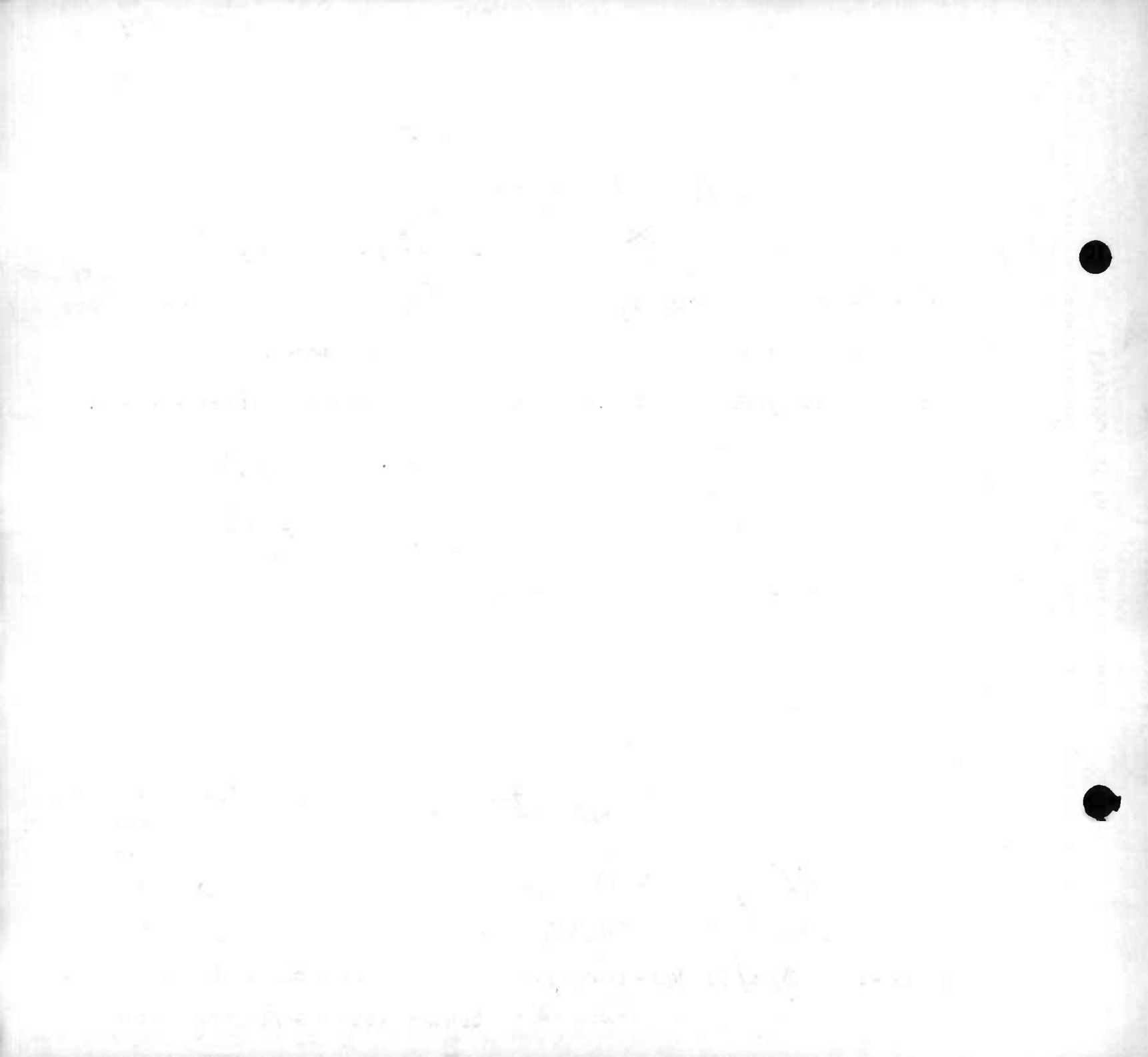
2001 10/10/01

2001 10/10/01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

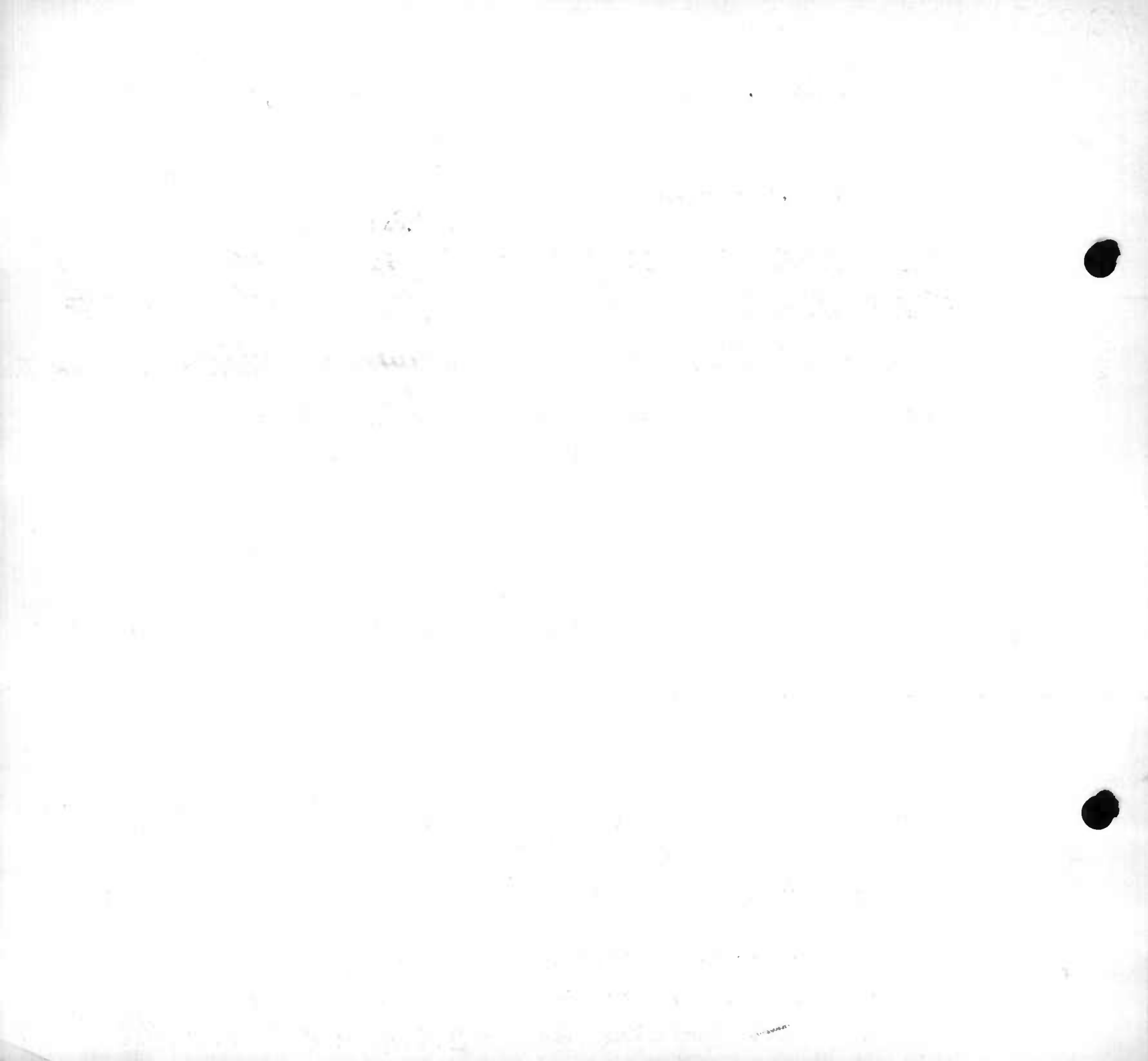
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|---|--|---|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. <u>183104</u> | | | | | | | | | |
| BIRTH NO. <u>71 2114</u> | | 1. NAME OF DECEASED (Type or Print) <u>Urie, Helen Elizabeth</u> | | | | 2. DATE AND HOUR OF DEATH <u>Feb. 28 1971 6:05 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u> | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Balt Maryland</u> B. COUNTY <u>U.S.A.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1141 W. Cross St.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-18-12</u> | 9. AGE (In years lost birthday) <u>58</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Md. Trust Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> | | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-03-2398</u> | | 17. INFORMANT <u>PT's husband</u> | | | ADDRESS <u>1141 W. Cross St.</u> | | |
| 18. <u>28571</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Anemia - unknown etiology</u> <u>splenomegaly</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>0</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 23</u> 19 <u>71</u> to <u>Feb. 28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Feb. 28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Chung M.D.</u> DEGREE 23C. PHYSICIAN'S NAME (Type) <u>CHUNG-JA CHUNG</u> DEGREE | | | | | | 23B. DATE SIGNED <u>2/28/71</u> | | 23D. ADDRESS <u>South Baltimore General Hosp.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3/3/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>MEADOWRIDGE CEMETERY</u> | | 24D. LOCATION (City, town, or county) (State) <u>Wash. Blvd DORSEY Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>SCHWAINBERG FUNERAL</u> | | ADDRESS <u>1126 W. Cross St.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

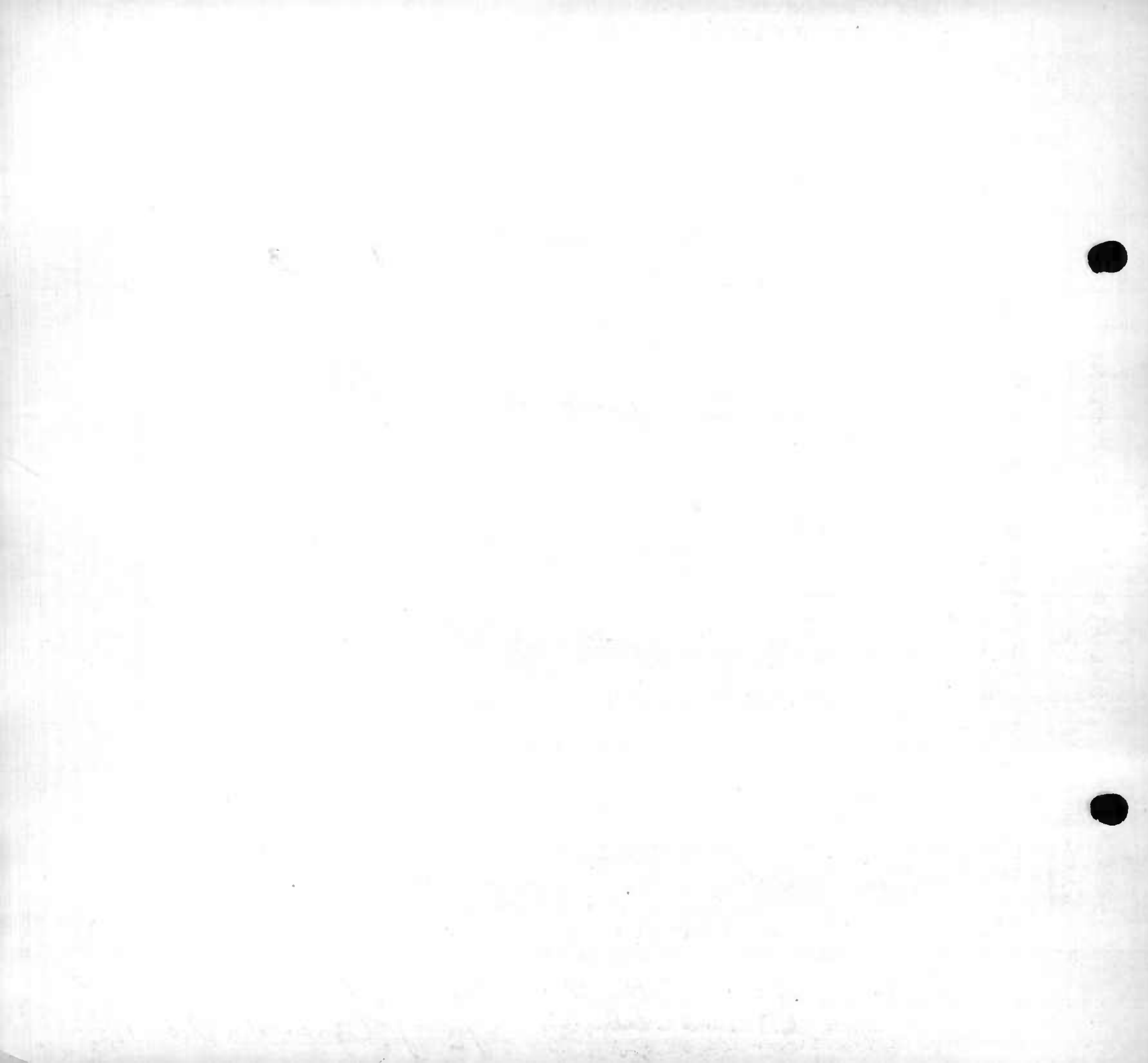
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2115</u> | |
|--|--|---|---|---|---|
| BIRTH NO. <u>71 2115</u> | | 1. NAME OF DECEASED (Type or Print) <u>Charles L. Metzler</u> | | 2. DATE AND HOUR OF DEATH <u>February 26, 1971</u> <u>12</u> <u>P.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>2301</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>110 W. Fort Avenue</u> | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>Male</u> | | | E. STREET AND NUMBER <u>110 W. Fort Avenue</u> | | |
| 6. RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/17/92</u> | |
| 9. AGE (In years last birthday) <u>78</u> | | 10. UNDER 1 Yr. Months Days | | 11. UNDER 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Ret.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | 13. FATHER'S NAME <u>John Metzler</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Baltimore Ad Heneretta Forster</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>25-03 9982</u> | | | 17. INFORMANT <u>John Metzler Above Address</u> | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PARKINSON'S DISEASE</u> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>1-4</u> <u>1968</u> to <u>2-26</u> <u>1971</u> that (1) (we) last saw the deceased alive on <u>1-30</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Peter Van B. Thorpe M.D.</u> | | | | 23B. DATE SIGNED <u>3-1-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Peter Van B. Thorpe M.D.</u> | | | | 23D. ADDRESS <u>Maryland 21043</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-1-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Louder Park Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>McClary 430 E. Fort Ave.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

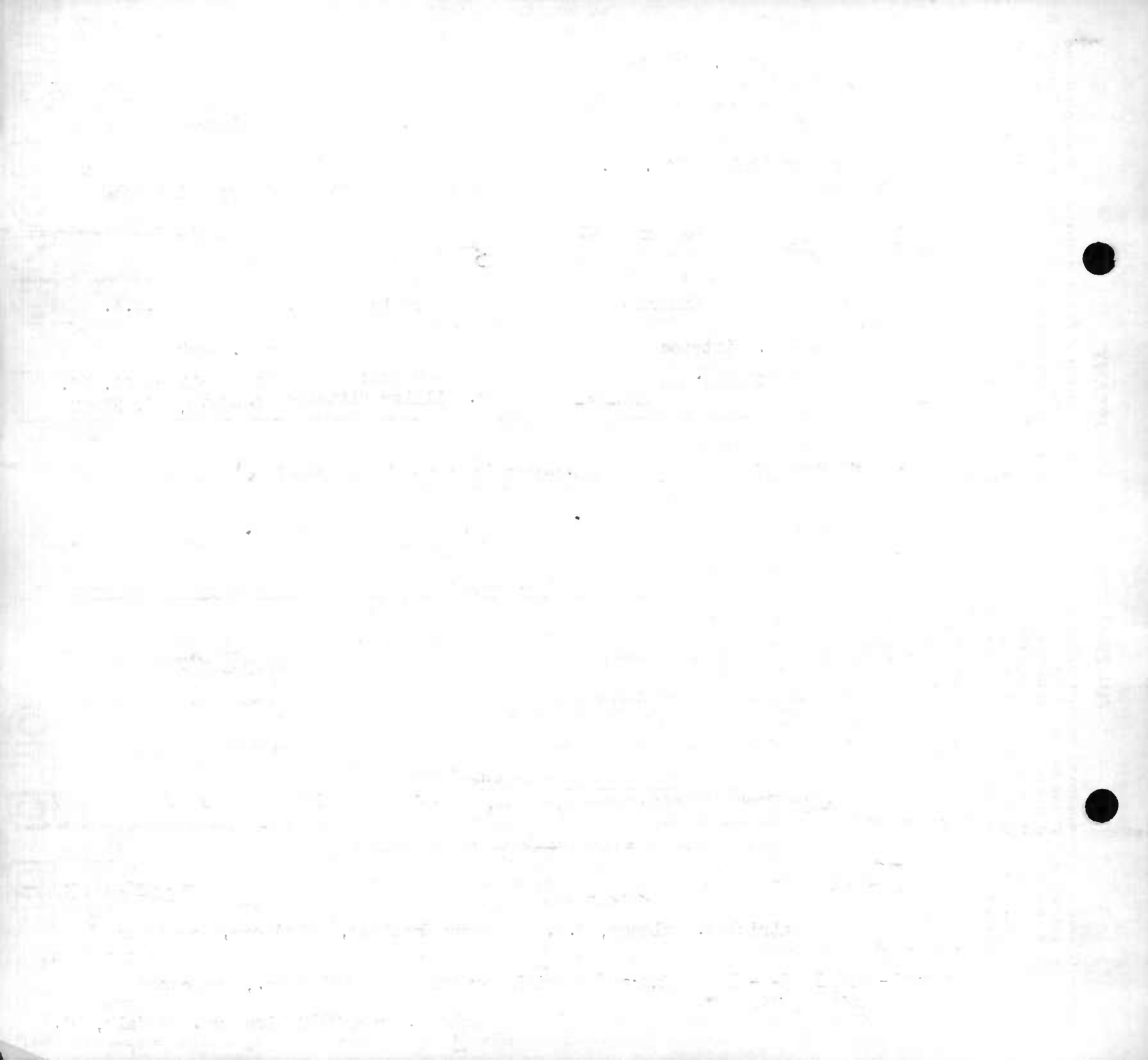
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BALTIMORE CITY HEALTH DEPARTMENT | |
|---|--|--|--|---|--|
| BIRTH NO. 71 2116 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 30912-35 | | | | Registered No. 71 2116 | |
| 1. NAME OF DECEASED (Type or Print) <u>ANZEL A. Peter</u> | | | 2. DATE AND HOUR OF DEATH <u>2/28/71</u> <u>4:30 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> (If not in hospital or institution, give street address or location) <u>Baltimore, Md.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>1801</u> | | |
| 5. SEX <u>male</u> | | | 6. RACE <u>caucasian</u> | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u> | | | 8. DATE OF BIRTH <u>8/19/97</u> | | |
| 9. AGE (In years lost birthday) <u>73</u> | | | 10. If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>unknown</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>unknown</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>unknown</u> | | |
| 13. FATHER'S NAME <u>unknown</u> | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u> | | | 16. SOCIAL SECURITY NO. <u>215-24-0858</u> | | |
| 17. INFORMANT <u>admission record</u> | | | ADDRESS | | |
| 18. <u>440.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO <u>Bilateral iliofemoral thrombosis</u> (B) DUE TO <u>arteriosclerotic peripheral vascular disease</u> (C) <u>unknown</u> | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>74 hrs.</u> | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>atrial fibrillation</u> | | |
| 19A. DATE OF OPERATION <u>2/27/71</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>bilateral iliofemoral thrombosis</u> | | |
| 20A. AUTOPSY? (Yes or No) <u>never</u> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>unknown</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>never</u> | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>never</u> | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>never</u> | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? <u>never</u> | | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>2/27</u> 19 <u>71</u> to <u>2/28</u> 19 <u>71</u> , that (I) <u>we</u> last saw the deceased alive on <u>2/28</u> 19 <u>71</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Fred R. Eilber</u> | | | 23B. DATE SIGNED <u>2/28/71</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Fred R. EILBER</u> | | | 23D. ADDRESS <u>University Hospital Balt. Md.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/2/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Green Haven Cem.</u> | |
| 24D. LOCATION (City, town, or county) <u>md</u> | | 24E. STATE <u>md</u> | | 24F. ADDRESS <u>23, mt</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>March 4, 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>John J. Casman & Son, Inc.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2117</u> | |
|---|--|--|---|--|--|
| BIRTH NO. <u>V33071 2117</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Vittetoe Jake M. Vittetoe</u> | | | 2. DATE AND HOUR OF DEATH <u>3/1/71 12:45 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy Hospital Balto. Md.</u> <u>Mercy Hospital, Baltimore</u> | | | A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | |
| | | | C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <u>5/7/01</u> 9. AGE (in years last birthday) <u>69</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>Canton RR</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>John M. Vittetoe</u> | | | 14. MOTHER'S MAIDEN NAME <u>Emma F. Cook</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>409-05-8862</u> | | |
| 17. INFORMANT Son: <u>Mr. William Vittetoe</u> | | | ADDRESS <u>3107 Sollers Pt. Rd. Dundalk, Md. 21222</u> | | |
| 18. <u>201X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Hodgkins</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | <u>myocardial infarct</u> | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-23</u> 19 <u>71</u> to <u>3-1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3-1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Patrick A. Moloney</u> | | | | 23B. DATE SIGNED <u>2/28/71 3/1/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Patrick A. Moloney, M.D.</u> | | | | 23D. ADDRESS <u>Mercy Hospital, Baltimore, Maryland</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal-Burial</u> | | 24B. DATE <u>3-4-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Jasper Memorial Gardens</u> | |
| 24D. LOCATION <u>Marion Co., Tennessee</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Saylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>John J. Duda</u> | |
| | | | | ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2118 | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. 71 2118 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Mr & Mrs G. Pickett</i> | | | 2. DATE AND HOUR OF DEATH <i>8:10 3/1/71</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i> | | | A. STATE <i>Maryland</i> B. COUNTY <i>Carroll</i> | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | C. CITY OR TOWN <i>Sykesville</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| | | | E. STREET AND NUMBER <i>Streaker Road</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>April 29, 1898</i> | 9. AGE (In years last birthday) <i>72</i> | If Under 1 Yr. Months: Days: Hours: Min. <i>10 2</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 13. FATHER'S NAME <i>Augustus Bidingier</i> | | | 14. MOTHER'S MAIDEN NAME <i>Mary Ritter</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>218-32-0207A</i> | | |
| 17. INFORMANT <i>John E. Pickett, Sr.</i> | | | ADDRESS <i>Same As #4</i> | | |
| 18. <i>445, 91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Shock</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Probable Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Gangrene @ leg 2° embolus @ hemorrhage 2° to embolus ASCVD, transverse myocardium</i> | | |
| 19A. DATE OF OPERATION <i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) <i>No</i> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/1/71</i> 19 to <i>3/1/71</i> 19 that (I) (we) last saw the deceased alive on <i>3/1</i> 19 <i>71</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>OB Owen M.D.</i> | | | 23B. DATE SIGNED <i>3/1/71</i> | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 24B. DATE <i>3/4/1971</i> | | |
| 24C. NAME of CEMETERY or CREMATORY <i>McKendree</i> | | | 24D. LOCATION <i>Howard, Md.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 4 1971</i> | | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | |
| 25C. FUNERAL DIRECTOR <i>C.M. Waltz</i> | | | ADDRESS <i>Box 326, Sykesville, Md.</i> | | |

July 1944

1. 1. 1944

2. 1. 1944

3. 1. 1944

4. 1. 1944

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BALTIMORE CITY HEALTH DEPARTMENT

71 2119

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 2119

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Arthur Steven Borisky | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 2 28 71 5:15 p. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) 38 University Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 28 71 5:15 p. M. | |
| 6. SEX male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Reisterstown | |
| 9. DATE OF BIRTH Dec. 31, 1950 | | 10. AGE (In years last birthday) 20 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 15. MOTHER'S MAIDEN NAME Bernice C. Depner | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 215-58-2813 | |
| 18. INFORMANT Arthur Borisky | | ADDRESS 501 Sunwood Ct. Reisterstown, Md. | |
| 19. CAUSE OF DEATH E812.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fracture of neck & craniocerebral injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ROAD | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Sunnyking Dr. & Church Road | | 22F. HOW DID INJURY OCCUR? Subject was driver of motorcycle which hit car. | |
| 22D. TIME OF INJURY (Approx.) Month (Year) (Hour) 2 28 71 5:00 p. M. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/1/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE March 3, 1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Evergreen Memorial Gardens | | 24D. LOCATION (City, town, or county) (State) Finksburg, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Jaben, M.D. | |
| 25C. FUNERAL DIRECTOR H. J. Selhardt | | ADDRESS Owings Mills, Md. | |

TO THE
TREASURER
OF THE
UNITED STATES
DEPARTMENT OF THE
TREASURY
WASHINGTON, D. C.

FOR THE
PURPOSE OF
REDEMPTION
OF THE
UNITED STATES
BOND

NO. 11-11-1918
11-11-1918

11-11-1918
11-11-1918

11-11-1918
11-11-1918

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11-11-1918

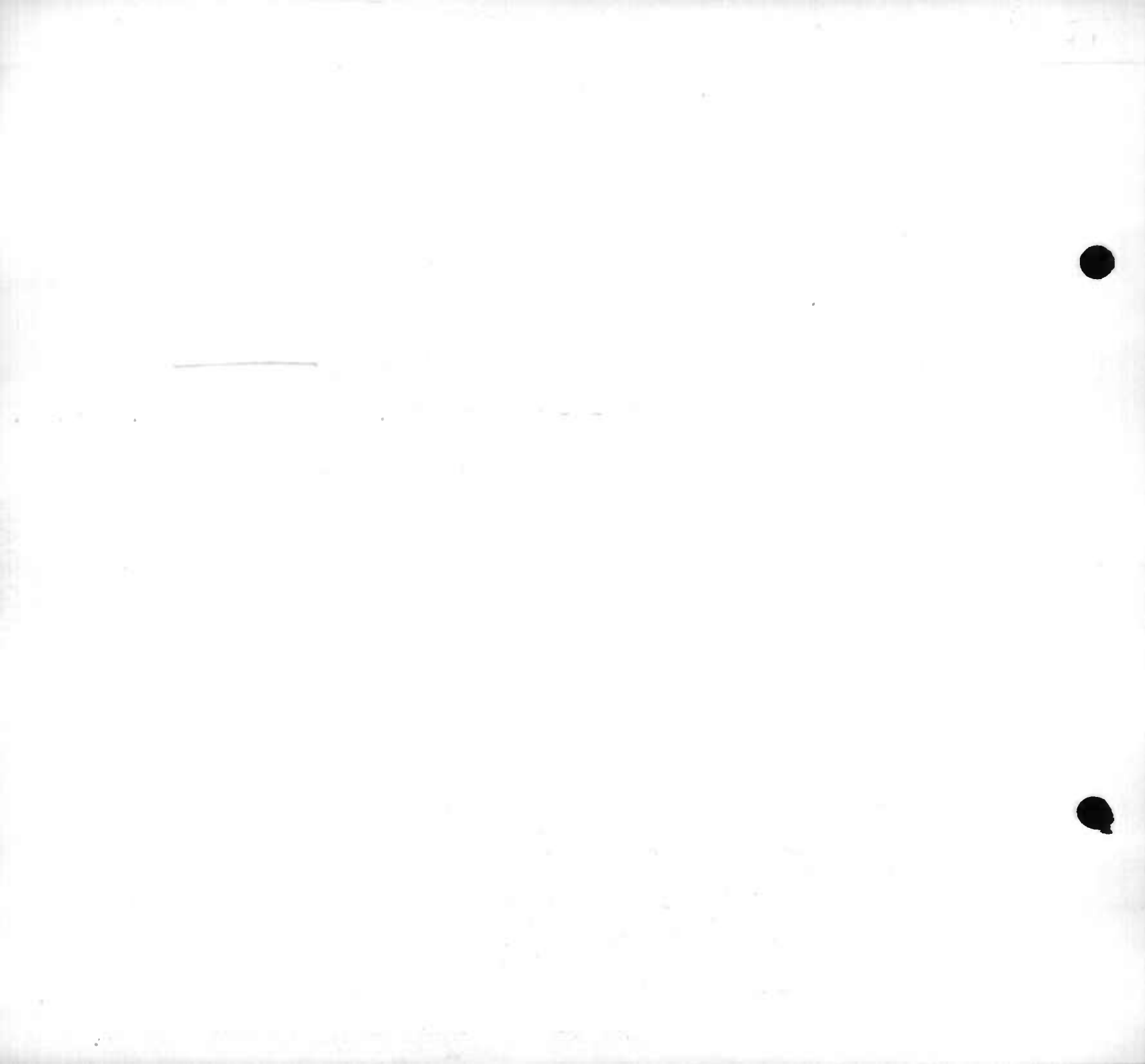
11-11-1918
11-11-1918

11-11-1918
11-11-1918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71</u> <u>2130</u> | |
|--|------------------|---|---------------------------------|--|--|
| BIRTH NO. <u>71</u> <u>2120</u> | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH <u>2/27/71</u> <u>5:30 a.m.</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>Lillian G. THOMAS</u> | | 2. DATE AND HOUR OF DEATH | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u> | | A. STATE <u>Md.</u> | | B. COUNTY <u>Harford</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>JOPPA</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>421 Enfield Rd 21085</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/25/91</u> | 9. AGE (In years last birthday) <u>79</u> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Homekeeping</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Henry Beatty</u> | | 14. MOTHER'S MAIDEN NAME <u>Kattie</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-03-8671</u> | | 17. INFORMANT <u>Margaret A. Thomas</u> ADDRESS <u>421 Enfield Rd. Joppa, Md. 21085</u> | |
| 18. <u>15381425019</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Ca Colon</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | <u>ASCD - Coronary insufficiency</u> <u>Diabetes mellitus - Peripheral gangrene</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2/6/71</u> 19__ to <u>2/27/71</u> 19__ that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2/27/71</u> 19__ and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE <u>Puig-Antich</u> | | | | 23B. DATE SIGNED <u>2/27/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Puig-Antich</u> | | | | 23D. ADDRESS <u>Sinai Hosp.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-1-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u> | |
| 24D. LOCATION <u>Baltimore</u> | | | | 24E. (City, town, or county) (State) <u>Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Feltz, Jr.</u> | | 25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u> ADDRESS <u>7401 Belair Rd. 21236</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 2121</u> | |
|---|-------------------------|---|---|---|--|--|--|
| BIRTH NO. <u>71 2121</u> | | 1. NAME OF DECEASED (Type or Print) <u>JOSEPH EDWARD WRIGHT JR</u> | | 2. DATE AND HOUR OF DEATH <u>2/15/1971</u> | | <u>7 45 P</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 355 SOUTHWAY APT 1 B</u> Homeland | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>214 Paddington Rd.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/20/1903</u> | | 9. AGE (In years lost birthday) <u>67</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Joseph Edward Wright</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Gertrude Sisselberger</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Mrs. Lucile H. Wright 214 Paddington Rd.</u> | | |
| 18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arterio-sclerotic Cardiac - Vascular Disease</u> <u>Terminal Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Gradual onset 2 hrs.</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>ack</u> <u>1950</u> to <u>Feb 15</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>Feb 15</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>W.H. Woody M.D.</u> | | | | 23B. DATE SIGNED <u>2-16-71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>W.H. Woody M.D.</u> | | | | 23D. ADDRESS <u>1403 Park one Baltimore</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/18/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Pikesville Balto Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D. I</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell Wiedefeld Home 6500 York Rd.</u> | | | |

Yes MW

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

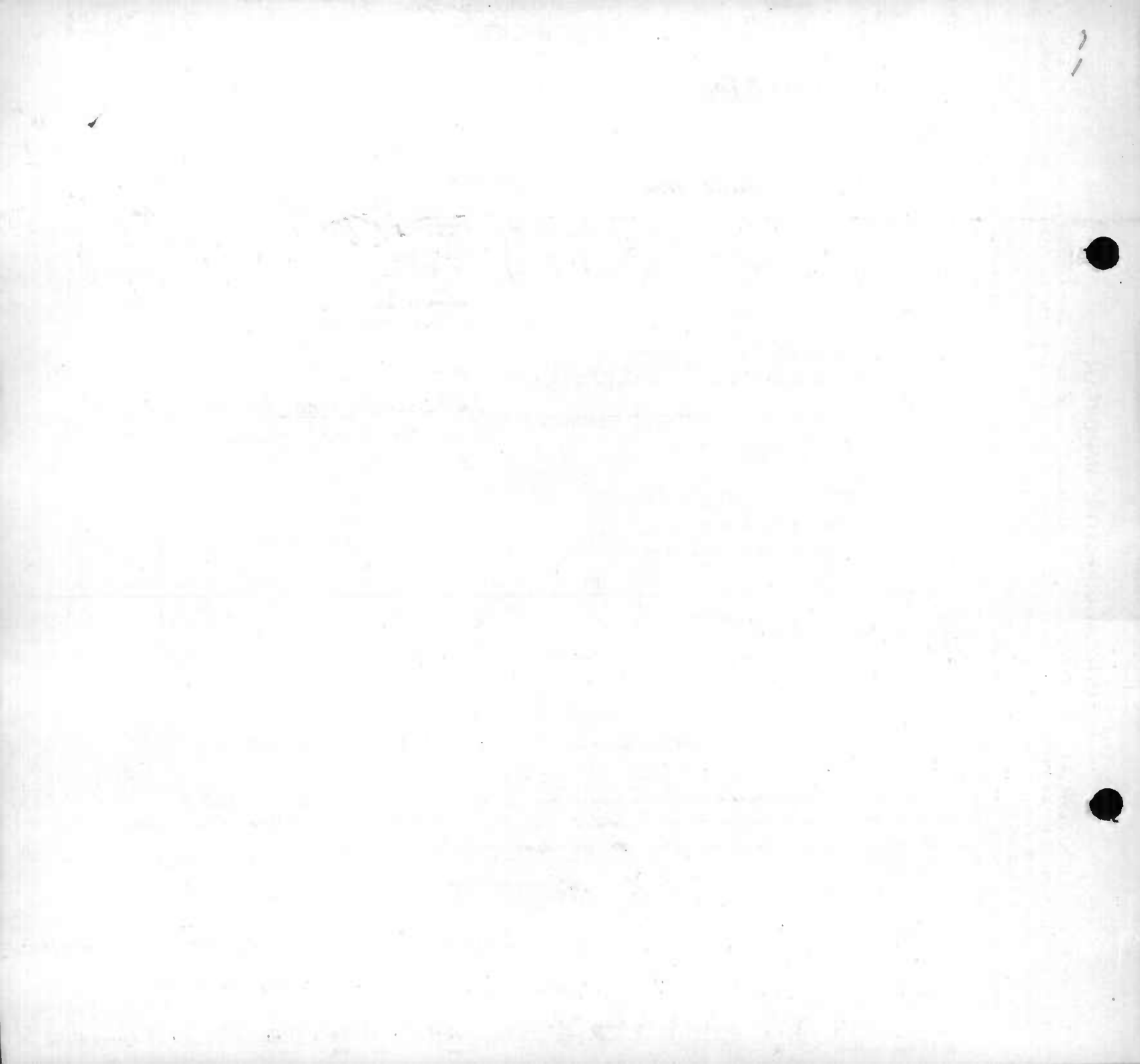
REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED Karel Hurrelbrinck (Type or Print) HUGO LAMBERTS HURRELBRINCK 3rd | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 110 Bellemore Road | | 3. DATE PRONOUNCED DEAD Month Day Year Hour February 25, 1971 11:15 A | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 3/15/1944 | | 10. AGE (In years lost birthday) 26 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Hugo K.L. Hurrelbrinck | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | |
| 15. MOTHER'S MAIDEN NAME Harriet Cullison | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 21 5425292 | | 18. INFORMANT Mrs. Harriet C. Quandt | |
| 19. CAUSE OF DEATH E 9531 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 110 Bellemore Road | | 22F. HOW DID INJURY OCCUR? Shot self | |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) Feb. 24 or 25, 1971 | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/25/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn Balto. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Jacoby, M.D. | |
| 25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home | | ADDRESS 6500 York Rd. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

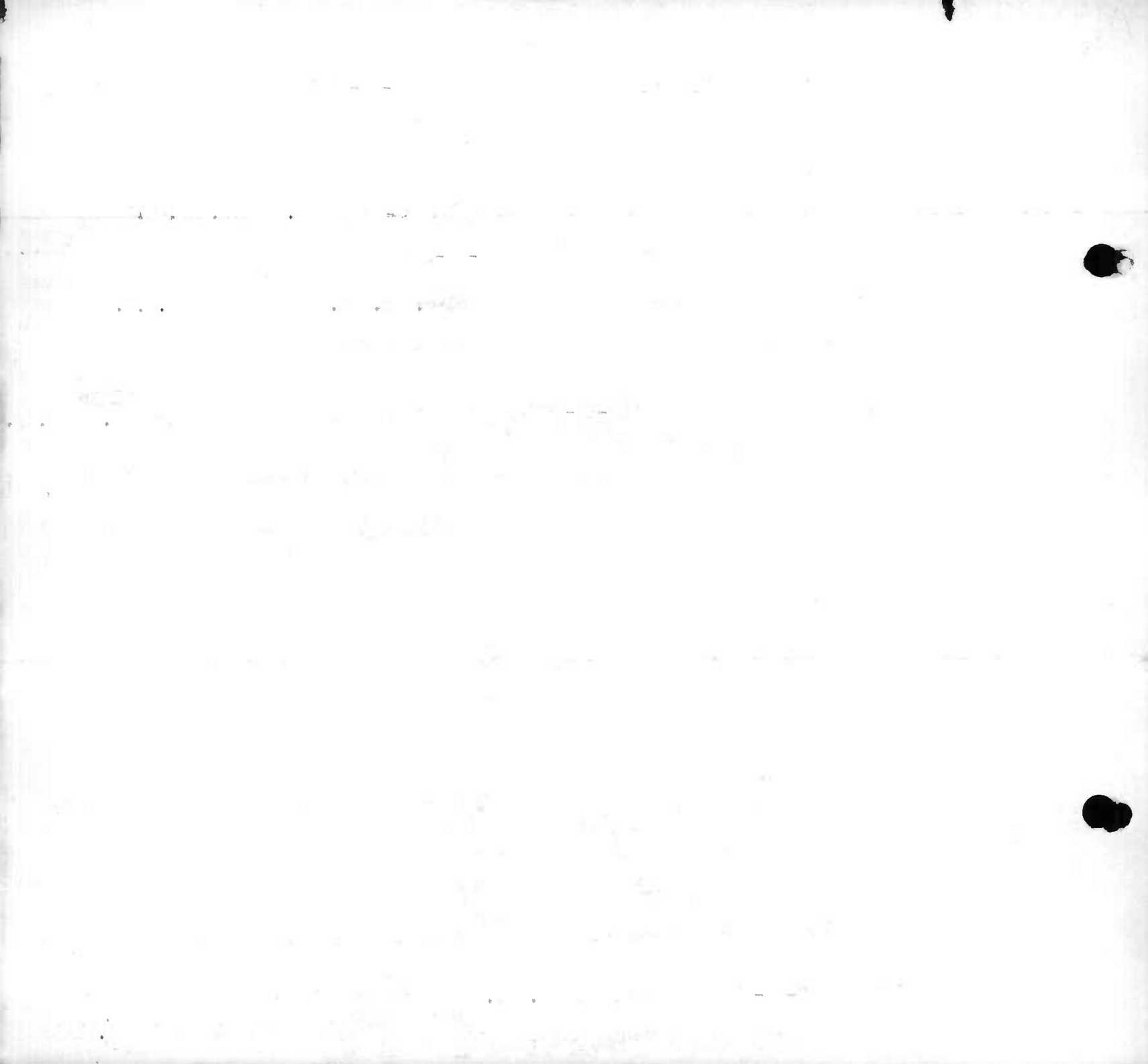
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|---|--|--|---|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. 71 2133 | | | | | REG. NO. 71 2133 | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mary M. Coyne</i> | | | | | 2. DATE AND HOUR OF DEATH <i>February 26, 1971</i> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>00 3626 Yolando Road</i> | | | | | A. STATE <i>Maryland</i> B. COUNTY <i>903</i> | | | | |
| | | | | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER <i>3626 Yolando Road</i> | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>11/22/'80</i> | 9. AGE (In years last birthday) <i>90</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>? Pittinger</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>?</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mr Richard Coyne 3424 Northwind Rd</i> | | | |
| 18. <i>4 12 41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH <i>Coronary heart failure, A.C.U.P.</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1950</i> to <i>2/26</i> 19 <i>71</i> , that (I) was last saw the deceased alive on <i>2/11</i> 19 <i>71</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Joseph R. Liberto, M.D.</i> | | | | | | 23B. DATE SIGNED <i>2/27/71</i> | | 23C. PHYSICIAN'S NAME (Type) <i>JOSEPH R. LIBERTO, M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | | 24B. DATE <i>3/1/'71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | | | | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 4 1971</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Gaber, M.D.</i> | | | | | | 25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i> | | | |
| 25D. ADDRESS <i>3000 E. Baltimore St</i> | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 2124 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 71 2124 | |
|--|---------|--|-----------------------------------|---|---|--|------------------------------|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Elizabeth Milchling | | | | 2-25-1971 12 30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 90 Hood Nursing Home | | | | Maryland Balto. | | | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 5001 Hazelwood Ave. Balto. Md. 21206 | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | | 9. AGE (In years (last birthday)) | 10. Under 1 Yr. Months Days | |
| F | W | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 5-24-1882 | | 88 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Housewife | | | Home | | Balto. Co. Md. | | U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Andrew Reinhardt | | | | Augusta Wolfurn | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| no | | | 219-16-7534 | | Miss Mildred Plumer 4303 Plumer Ave. Balto. Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | Circulatory failure | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | ASCVD. with Arteric disease | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/15/1968 to 2/25/1971 that (I) (we) last saw the deceased alive on 2/18/1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| [Signature] | | | | 2/27/1971 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Adrian M. Sommer | | | | 1011 Frederick Rd. Balt. Md. 21228 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2-27-71 | | Jerusalem Luth. Ch. Cemetery | | Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | |
| MAR 4 1971 | | John E. Fisher, M.D. | | Lassahn Funeral Home 7401 Belair Rd. 21236 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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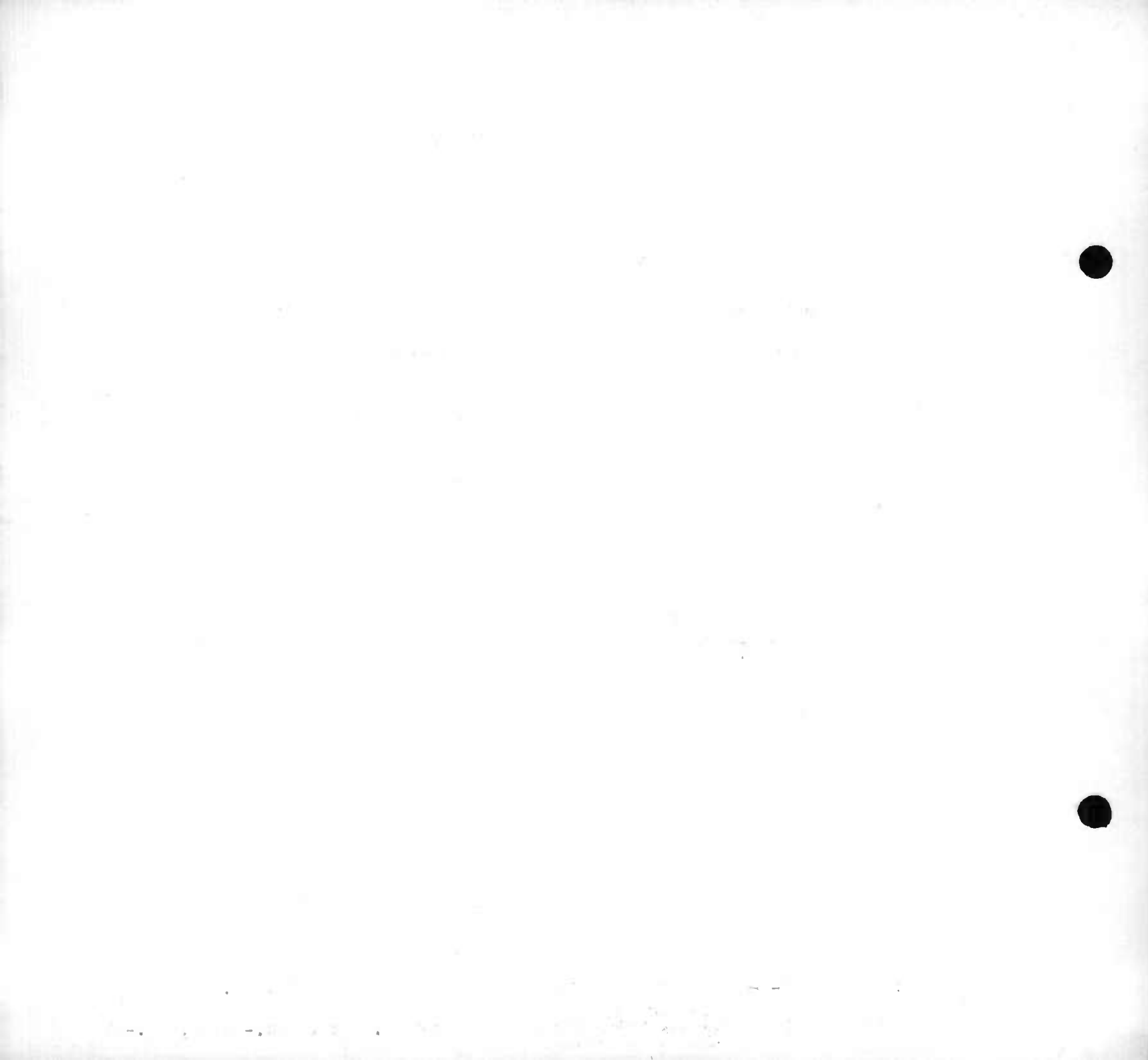
2001

71 2125

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 2125

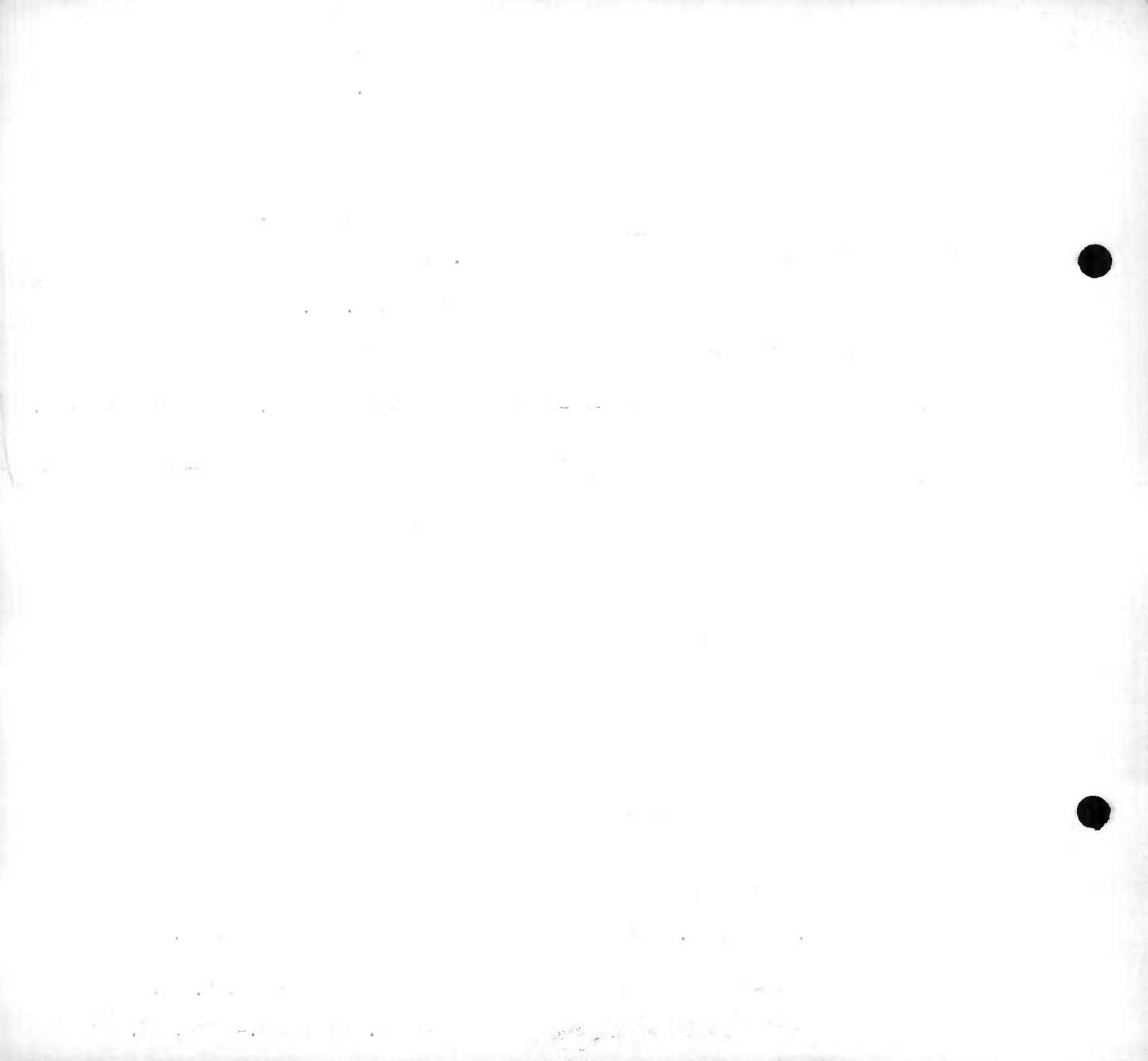
| | | | | | |
|---|---------------------|---|---|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) NILES ROSS | | 2. DATE AND HOUR OF DEATH 2-25-71 3:45 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MONTE BELLO STATE HOSPITAL | | | A. STATE Maryland | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | B. COUNTY BALTIMORE | | |
| C. CITY OR TOWN BALTIMORE | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER 4712 PIMLICO RD. | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-3-97 | 9. AGE (in years last birthday) 73 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY Miner | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME Benjamin Ross | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II | | | | 14. MOTHER'S MAIDEN NAME Carrie Weed | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT MRS. RUSSELL ENLATI | |
| 18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma of the lung, left | | | | ADDRESS 206 FALLBROOK CARBONDALE, PA. ST. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-3-71 19 71 to 2-25 19 71 that (I) (we) last saw the deceased alive on 2-25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Elsa M. Goris M.D. DEGREE | | | | 23B. DATE SIGNED 2-25-71 | |
| 23C. PHYSICIAN'S NAME (Type) ELSA M. GORIS M.D. DEGREE | | | | 23D. ADDRESS MONTEBELLO STATE HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 3-1-71 | | 24C. NAME of CEMETERY or CREMATORY Valley View | |
| 24D. LOCATION (City, town, or county) (State) Montdale, Pa. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Balto, Md.-14 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2126</u> | |
|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) MARGARET MARIE MARTIN | | 2. DATE AND HOUR OF DEATH Feb. 27, 1971 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 5409 BELLE VISTA AVENUE | | A. STATE Maryland | | B. COUNTY 2734 | |
| 5. SEX female | | 6. RACE caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH Aug. 16, 1911 | |
| 13. FATHER'S NAME Charles Whitecotton | | 14. MOTHER'S MAIDEN NAME Dovie Richards | | 9. AGE (In years last birthday) 59 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 233-26-1891 | | 17. INFORMANT Gerald Leonard Martin, 5409 Belle Vista Ave. | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Coronary occlusion (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD & Hyperlipidemia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 23 1959 to Feb 27 1971 that (I) (we) last saw the deceased alive on Feb 7 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Benigno R. Lazaro | | | | 23B. DATE SIGNED 2-28-71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Benigno R. Lazaro | | | | 23D. ADDRESS 109 Dundalk Ave, Dundalk, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 3-2-71 | | 24C. NAME OF CEMETERY OR CREMATORY Evergreen | |
| 24D. LOCATION (City, town, or county) (State) Wood County, W. Va. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Leonard J. Rack, Inc.-Balto, Md. | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2127</u> | |
|--|---------------------|---|--|--|--|
| BIRTH NO. <u>71 2127</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>CHARLES E. WARING</u> | | 2. DATE AND HOUR OF DEATH <u>MD MARCH 2, 1971</u> <u>7³⁵ P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hosp</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>501 W. University Pkwy</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/10/03</u> | 9. AGE (In years last birthday) <u>67</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired physician</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>chemist</u> | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME <u>EDWARD WARING</u> | | 14. MOTHER'S MAIDEN NAME <u>ETTA (Unknown)</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>382X1</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE <u>Chronic bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF <u>2 weeks anoxia</u> (B) <u>anemia</u> DUE TO, OR AS A CONSEQUENCE OF <u>A</u> (C) <u>Congestive heart failure (old MI)</u> <u>1962</u> | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr?</u> <u>1 wk</u> <u>1 wk</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2/12</u> 19 <u>71</u> to <u>3/2</u> 19 <u>71</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/2</u> 19 <u>71</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE <u>David J. Powner, MD</u> | | | | 23B. DATE SIGNED <u>3/2/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DAVID J. POWNER, MD</u> | | 23D. ADDRESS <u>Union Memorial Hosp</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>3-4-71</u> | | 24C. NAME OF CEMETERY <u>JOHNS HOPKINS MEDICAL SCHOOL</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8, 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u> | | 25C. NAME OF MORTUARY SERVICE <u>MORTUARY SERVICE - BCMB</u> | |

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P646

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2128

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) G.J. Anthony Preller | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 27 71 5:30 a.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1102 | |
| 9. DATE OF BIRTH June 22, 1911 | | 10. AGE (In years lost birthday) 59 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Preller | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXX Maintenance | |
| 15. MOTHER'S MAIDEN NAME Elizabeth Burtuer | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11 | |
| 17. SOCIAL SECURITY NO. 219-01-6358 | | 18. INFORMANT Mrs Thefesa Preller 2801 White Ave. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 511 Park Ave. 1102 | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 2 27 71 4:50 a.m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? shot self | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 2/27/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | |
| 25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Md | | 25D. ADDRESS | |

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UNITED STATES DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY
WASHINGTON, D. C.
JAN 10 1917
MEMORANDUM FOR THE SECRETARY
SUBJECT: [Illegible]

[Illegible text block containing multiple paragraphs of a memorandum]

Very respectfully,
[Illegible Signature]

UNITED STATES DEPARTMENT OF COMMERCE
JAN 10 1917

FUNERAL DIRECTOR: IMPORTANT

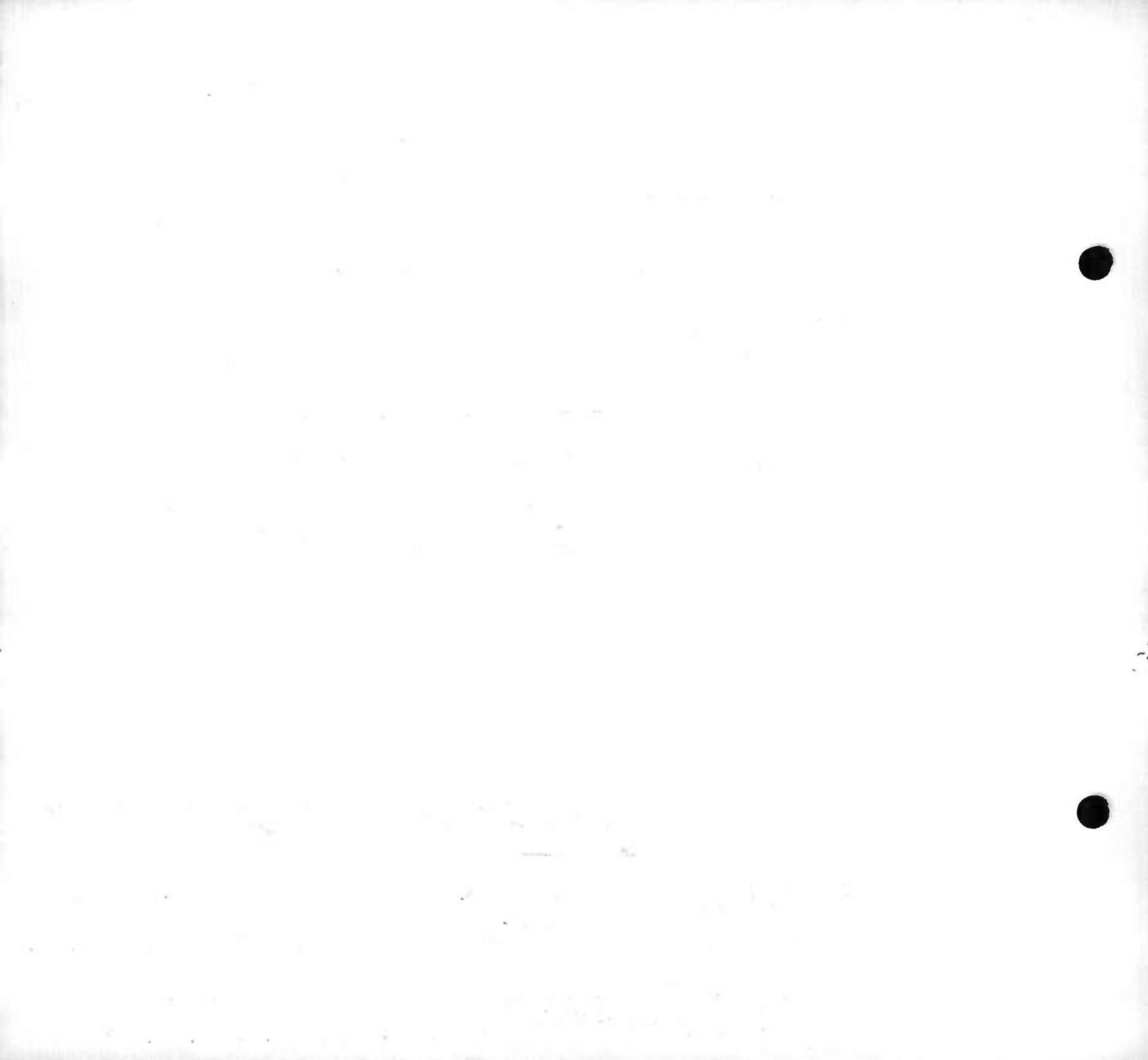
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 2129

| | | | |
|---|--|--|--|
| BIRTH NO. 71 2129 | | 2. DATE AND HOUR OF DEATH FEBRUARY 28, 1971. 2 AM | |
| 1. NAME OF DECEASED (Type or Print) MAGDALENA (LENA) SCHMIDT | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3900 PINKNEY ROAD | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2730 | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH APRIL 22, 1885 9. AGE (In years last birthday) 85 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME FRANCISCO MARCHIODI | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. 212-52-8949 | |
| 17. INFORMANT MR. JOHN C. SCHMIDT | | ADDRESS (SAME) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardio Respiratory Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (CVA) (B) Generalized Cerebral DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (C)..... | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JAN 29 1971 to FEB 28 1971 that (I) (we) last saw the deceased alive on FEB 28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Willard Applefeld | | 23B. DATE SIGNED 3/1/71 | |
| 23C. PHYSICIAN'S NAME (Type) WILLARD APPLEFELD MD. | | 23D. ADDRESS 6615 REISTERSTOWN ROAD, BALTO. MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/4/71 | |
| 24C. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR LEO ARND J. RUCK, INC. BALTO. MD. 21214 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2130</u> | |
|---|----------------------|--|---------------------------------|--|--|
| BIRTH NO. <u>71 2130</u> | | 1. NAME OF DECEASED (Type or Print) <u>FRANCES H. ALDERMAN</u> | | 2. DATE AND HOUR OF DEATH <u>2/27/71</u> <u>537</u> P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>33rd + Calvert</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto. City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1608 Sherwood Ave.</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-24-89</u> | 9. AGE (In years last birthday) <u>81</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>George Christian Habighurst</u> <u>-Christian-VonHabighurst-</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Josephine Gobreight</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>21305-4519</u> | | 17. INFORMANT <u>Mrs. Carlotta Gundersdorff</u> ADDRESS (Same) | |
| 18. <u>43791</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. <u>II</u> | | CAUSE OF DEATH IMMEDIATE CAUSE <u>Brain stem CVA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Cerebrovascular Disease 20 yrs.</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/27/71</u> 19 <u>71</u> to <u>2/27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>2/27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>David C. Moses MD</u> | | | | 23B. DATE SIGNED <u>2-27-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>David C. Moses MD</u> | | | | 23D. ADDRESS <u>2249 ROSENE DRIVE (2109)</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/2/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u> | | (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | |

V.S. 153

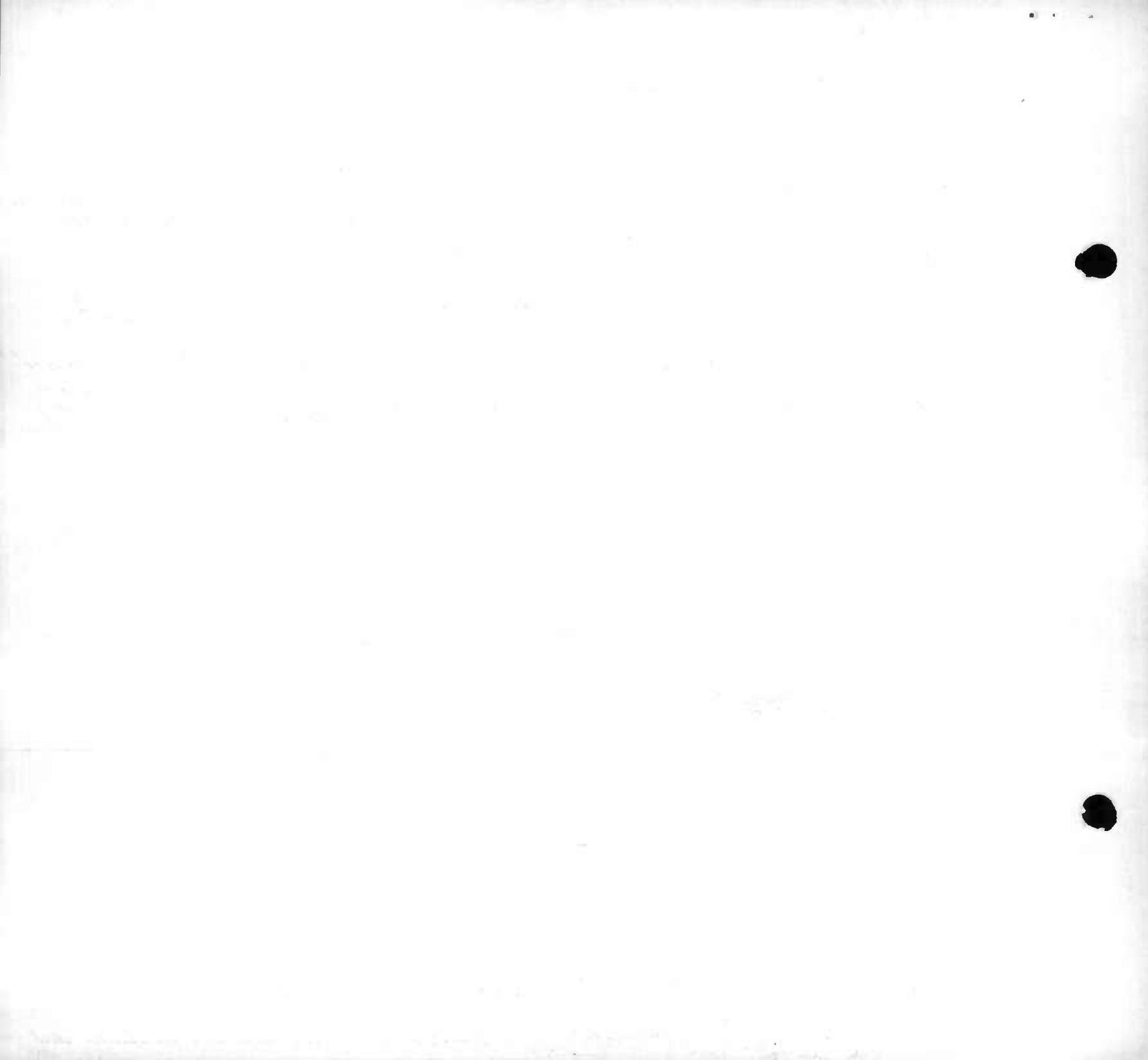
3-15-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 71 2131 | |
|--|--|--|--|---|--|---|--|
| BIRTH NO. B53071 2131 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BANDY, DOUGLAS S. | | | | 2. DATE AND HOUR OF DEATH 3-3-71 7:30 a.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD BON SECOUR HOSP. FAYETTE ST. - BALTO. - 23. | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL 5200 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOUR HOSP. FAYETTE ST. - BALTO. - 23. | | | | C. CITY OR TOWN B'EVERN | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 1-23-14 | | 9. AGE (In years lost birthday) 57 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EQUIPMENT OPERATOR. C.S. Langenfetter | | | | 10B. KIND OF BUSINESS OR INDUSTRY Roads, VA | | 11. BIRTHPLACE (State or foreign country) U.S.A. | |
| 13. FATHER'S NAME S.G. Bandy | | | | 14. MOTHER'S MAIDEN NAME Katherine Ackerman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | | 16. SOCIAL SECURITY NO. 224-09-3736 | | 17. INFORMANT Mrs Irene V. Bandy | |
| 18. CAUSE OF DEATH 16 RLL I | | | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOGENIC CARCINOMA, RLL. with pleural effusion | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASHD with CHF. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: ASHP with CHF. | | Months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Aneurysm of abdominal aorta | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | Months | |
| 19A. DATE OF OPERATION 2-2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ASHP with CHF. | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Home | | | |
| 21D. TIME OF INJURY (APPROX.) 2:00 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Slip | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 4, 1971 to March 3, 1971 that (I) (we) lost saw the deceased alive on March 3, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Chun S. Prueksapong, M.D. | | | | 23B. DATE SIGNED March 3, 71 | | | |
| 23C. PHYSICIAN'S NAME (Type) CHUN SAIK PRUEKSAPONG M.D. | | | | 23D. ADDRESS Bon Secour Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/6/71 | | 24C. NAME OF CEMETERY OR CREMATORY Blue Ridge Memorial Gardens | | 24D. LOCATION (City, town, or county) (State) Salem VA. | |
| 25A. DATE RECEIVED BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Samuel J. ... | | ADDRESS Clarkeburg, Md. | |



CERTIFICATE OF DEATH

REG. NO. 71 2132

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Williams

IDA

2. DATE AND HOUR OF DEATH

MARCH 2 1971 1 645 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland

21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

736 South Decker Avenue 21224

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

12-2-98

9. AGE (in years last birthday)

72

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housekeeper

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City Hosp.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Lentz

14. MOTHER'S MAIDEN NAME

Augusta Martin

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

21722-2365

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH: Records Baltimore, Maryland 21224

18.

707.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

RESPIRATORY + CARDIOVASCULAR

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

- 5

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

DECUBITUS ULCERS.

19A. DATE OF OPERATION

12/23/71

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

DECUBITUS ULCERS

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/13 to 3/2 1971 and that (I) (we) last saw the deceased alive on 3/2 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ivens LeFlore M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

3/2/71

23C. PHYSICIAN'S NAME (Type)

Ivens LeFlore M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-6-71

24C. NAME OF CEMETERY OR CREMATORY

Mt. Carmel Cemetery

24D. LOCATION

Baltimore

(City, town, or county)

Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 4 1971

25B. NAME OF REGISTRAR

Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR

Thelma A. Hoffmann 3218 Hudson St

ADDRESS

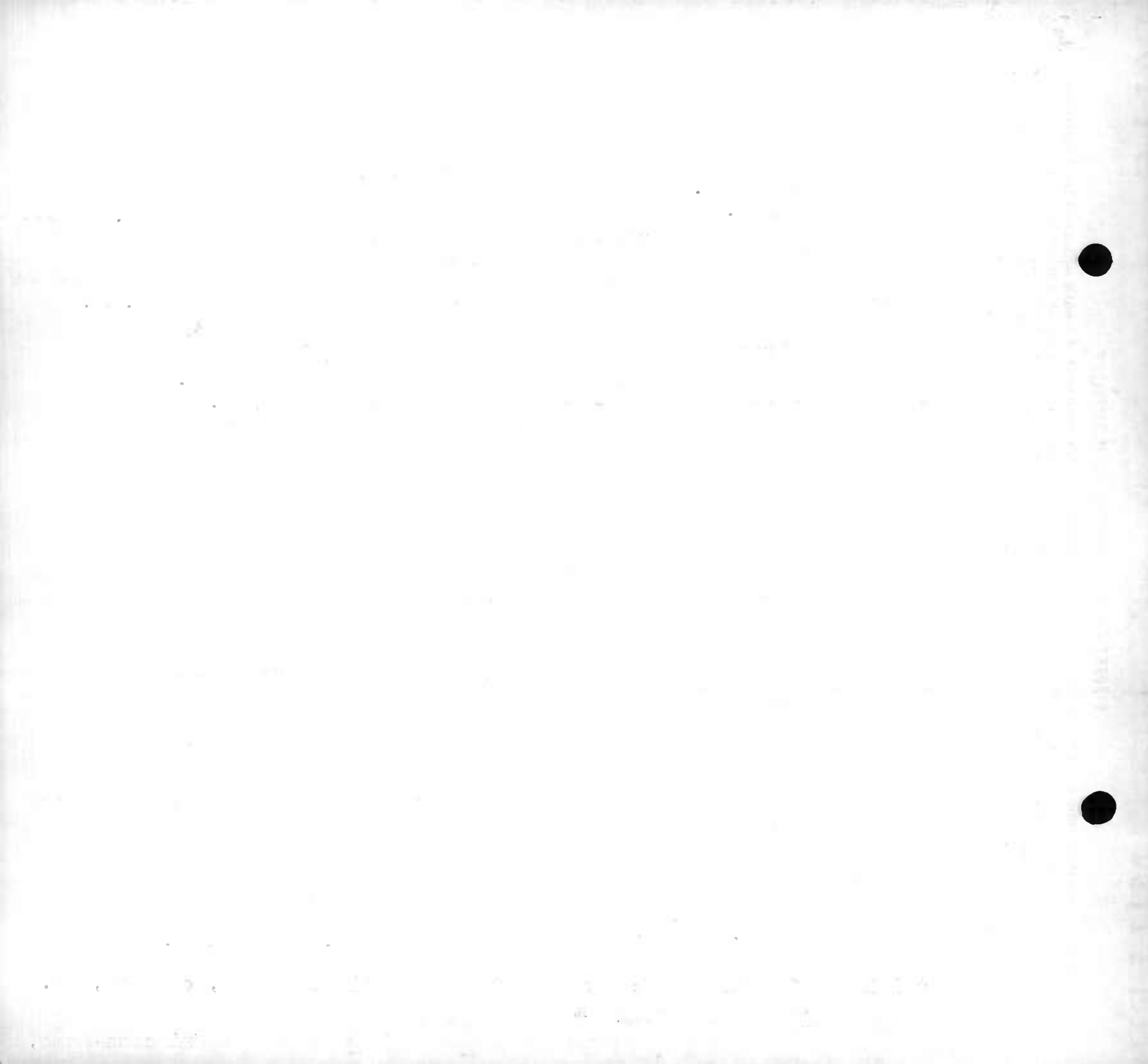
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| T65-71 2133 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 71 2133 | |
|--|-------------------------|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) GORDON TURNER | | 2. DATE AND HOUR OF DEATH 3-1-71 4:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland | | B. COUNTY Princess Ann | |
| | | | | C. CITY OR TOWN Princess Anne | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER Somerset Heights Princess Ann Md. 21853 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-8-31 | 9. AGE (In years last birthday) 39 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Carroll Turner | | | | 14. MOTHER'S MAIDEN NAME Iva Larson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean | | 16. SOCIAL SECURITY NO. 220-26-8603 | | 17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224 | | | |
| 18. 20571 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTRACEREBRAL BLEED ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. THROMBOCYTOPENIA MYELO-MONOCYTIC LEUKEMIA | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days ~4 days 5 mos | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 2-11-71 19 70 to 3-1 19 71 that (1) (we) lost saw the deceased alive on 3-1 19 71 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Richard K. Maza M.D. | | | | 23B. DATE SIGNED 3/1/71 | | 23C. PHYSICIAN'S NAME (Type) Richard K. Maza M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/4/71 | | 24C. NAME of CEMETERY or CREMATORY Beechwood Cemetery | | 24D. LOCATION Princess Anne, Somerset, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4 | | 25B. NAME OF FUNERAL DIRECTOR Robert E. Talley | | 25C. FUNERAL DIRECTOR James G. Lunn | | ADDRESS Princess Anne, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 2134

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BARBARA NARBUT

2. DATE AND HOUR OF DEATH

3/2/71 9:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00834 Hollins St.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Ind.

B. COUNTY

C. CITY OR TOWN

Balti.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

834 Hollins St. - 21201

5. SEX

F

6. RACE

W.

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

7/15/1884

9. AGE (in years
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Semonster

10B. KIND OF BUSINESS OR INDUSTRY

Clothing Co.

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

Zilaitis

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215-09-705

17. INFORMANT

Leonard Narbut - 834 Hollins St.

ADDRESS

18. 4/2/71

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic cardiovascular disease 4 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Generalized arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 1966 to March 1971
that (I) (we) last saw the deceased alive on March 1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John E. Kudirka

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

3.3.71

23C. PHYSICIAN'S
NAME (Type)

J. KUDIRKA

23D. ADDRESS

2151 Wilkens ave Balt. md

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/6/71

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer

24D. LOCATION

(City, town, or county)

Balti. Ind.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 4 1971

25B. NAME OF REGISTRAR

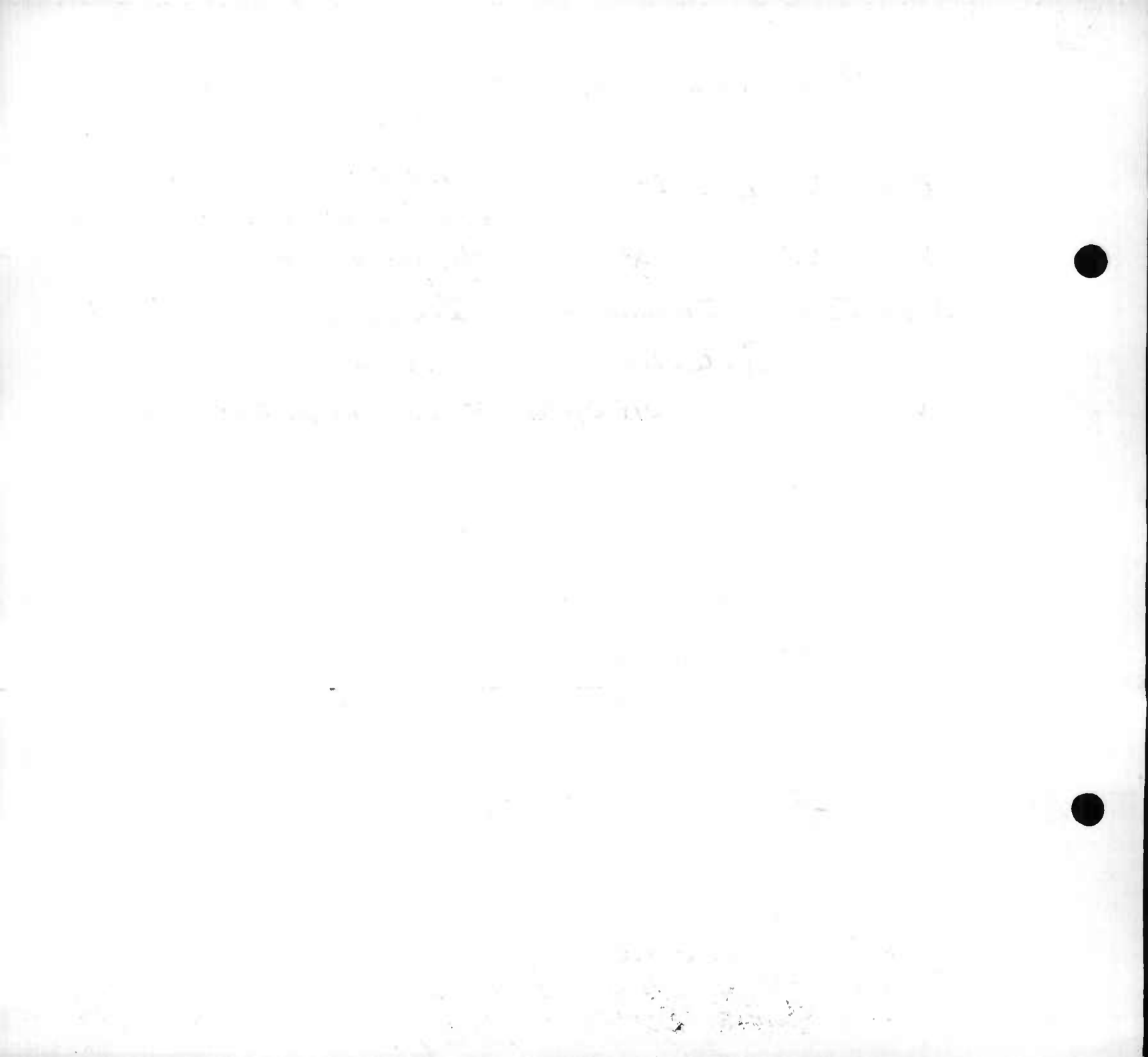
John E. Kudirka

25C. FUNERAL DIRECTOR

John E. Kudirka

ADDRESS

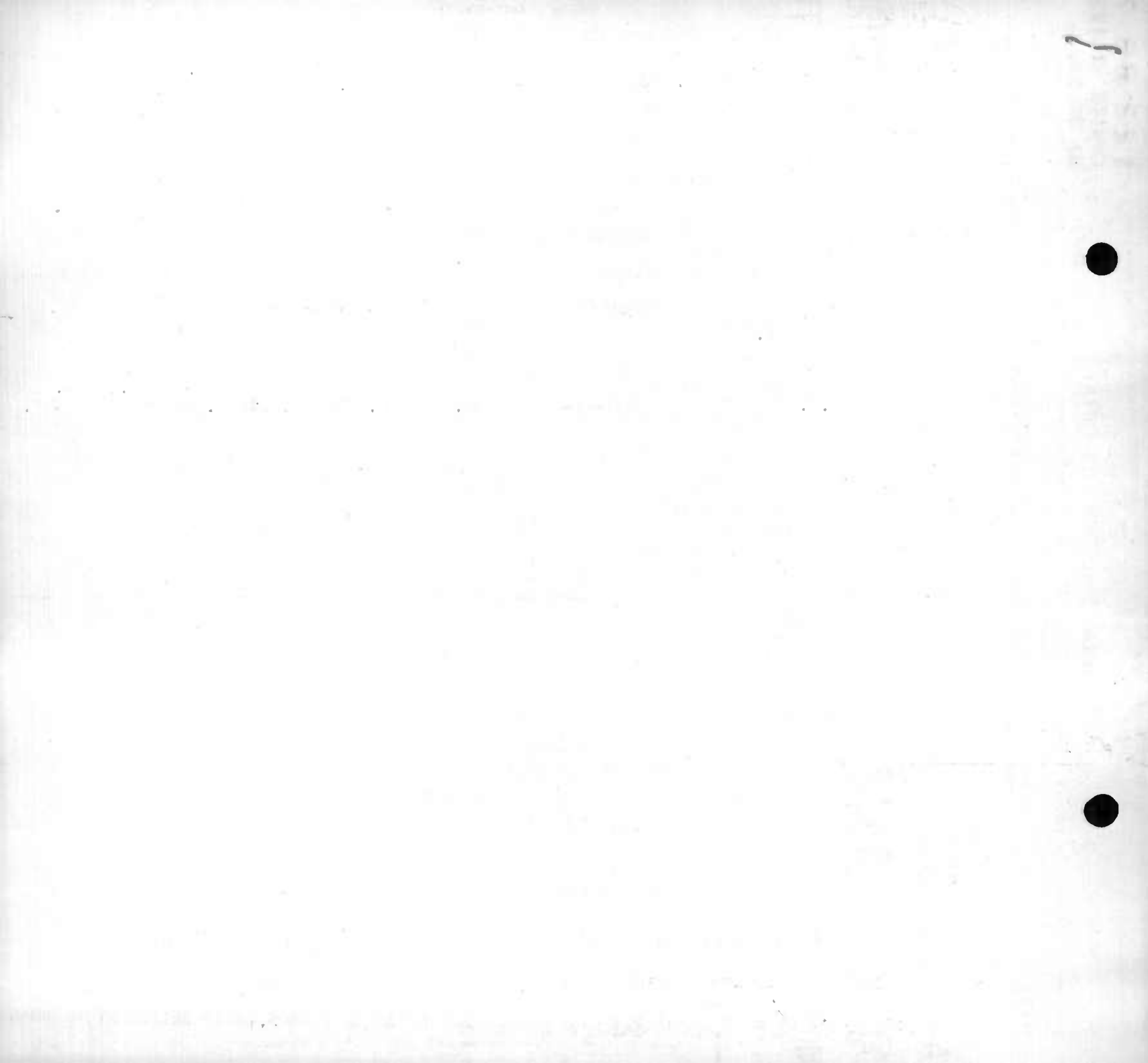
2151 Wilkens Ave Balt. Ind.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

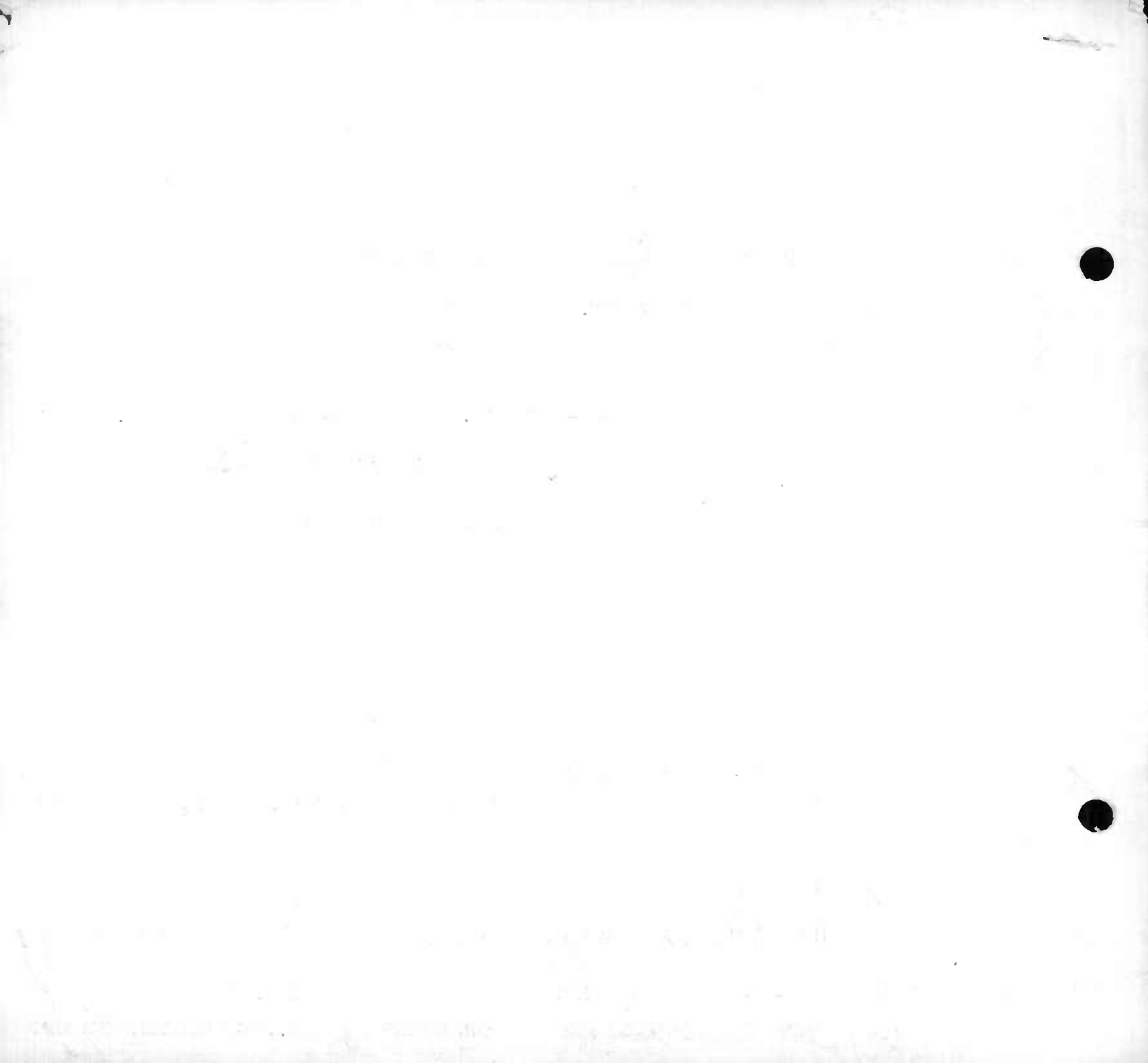
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2135 | |
|---|---------|---|------------------|--|-----------------------------|
| BIRTH NO. 122 88 | | JULIUS L. GRUBER | | DATE AND HOUR OF DEATH 2/26/71 3:45 AM | |
| 1. NAME OF DECEASED (Type or Print) | | JULIUS L. GRUBER | | 2. DATE AND HOUR OF DEATH | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | M. 1201 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | MARYLAND BALTIMORE CITY | | C. CITY OR TOWN | |
| 33 THE JOHNS HOPKINS HOSPITAL | | BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | 116 W. UNIVERSITY PARKWAY | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days |
| MALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 1-6-97 | 74 | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETAIL | | MERCHANT | | BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| B. MEYER GRUBER | | DELIA LOUIS | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES W.W. I NAVY | | 217-09-0852 | | BROADVIEW APTS., APT. 1401 | |
| 18. CAUSE OF DEATH | | 19. MEDICAL CERTIFICATION | | 20. DATE SIGNED | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 23B. DATE SIGNED | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | 2/26/71 | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/25 19 71 to 2/26 19 71, that (I) (we) last saw the deceased alive on 3:45 2/26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| Paul Whelan M.D. BCh BAO | | PAUL WHELAN M.D. BCh BAO | | Johns Hopkins Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 2-28-71 | | HEBREW FRIENDSHIP | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 4 1971 | | Robert E. Taylor, M.D. | | SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

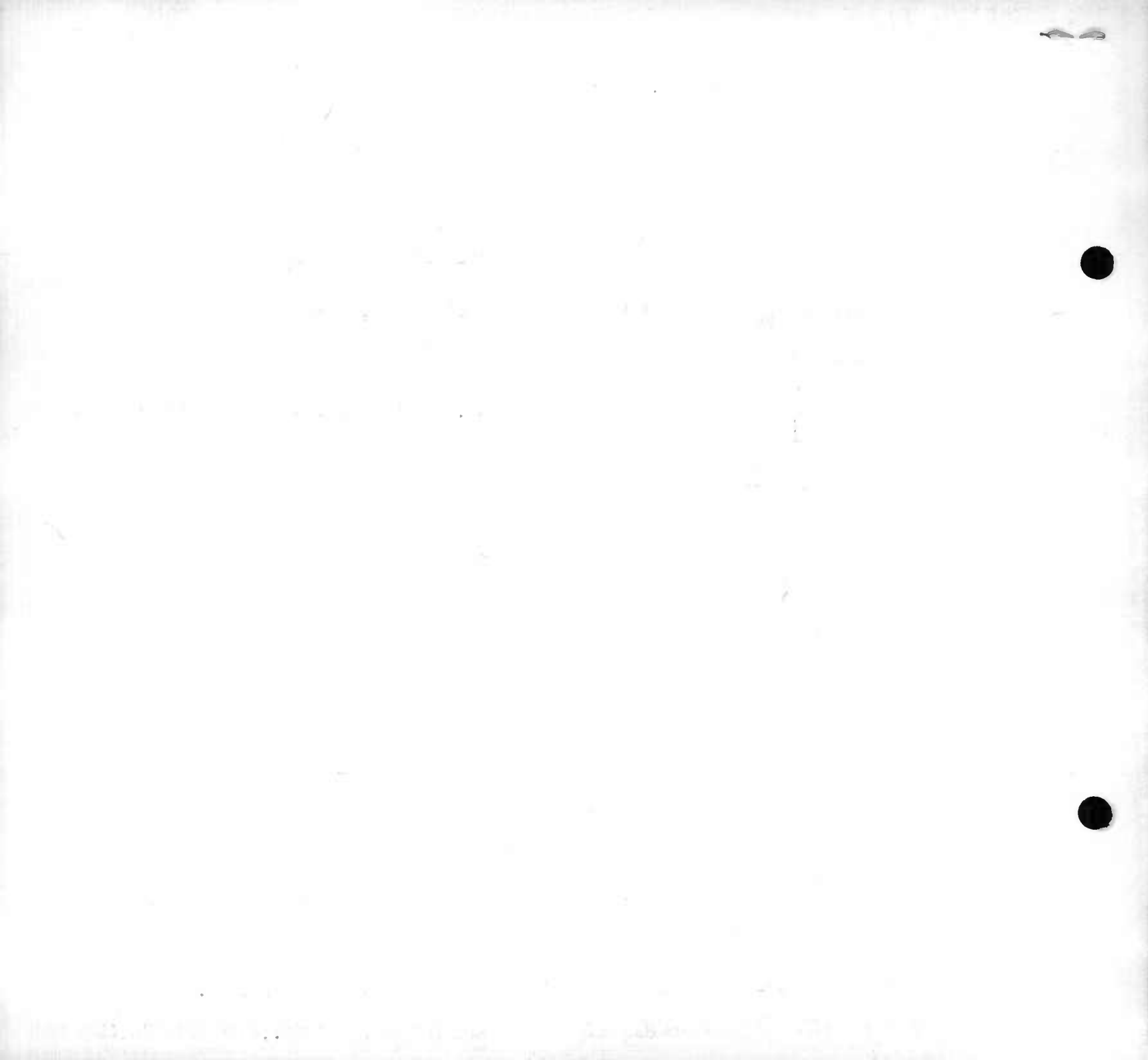
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2136</u> |
|--|-----------------------------|--|---|---|
| C500 BIRTH NO. <u>71 2136</u> | | 1. NAME OF DECEASED (Type or Print) <u>COHN - SAMUEL.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai hospital</u> | | 2. DATE AND HOUR OF DEATH <u>9 45 PM</u> <u>2/26/71</u> M. | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Baltimore - Md</u> B. COUNTY <u>5300</u> | | C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER <u>2535 SMITH AVENUE</u> | | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-15-1885</u> | 9. AGE (in years last birthday) <u>85</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>HOSIERY MFG.</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | |
| 13. FATHER'S NAME <u>HYMAN COHN</u> | | 14. MOTHER'S MAIDEN NAME <u>ETTA ?</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>216-05-6835</u> | | 17. INFORMANT <u>MRS. MIRIAM CUMMINS, 2535 SMITH AVE. #21209</u> |
| 18. <u>43691</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>CVA - embolus</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>3-2 days.</u> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory Depression</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-24</u> 19 <u>71</u> to <u>2-26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on _____ 19_____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>R. Hoorazar, M.D.</u> DEGREE | | | | 23B. DATE SIGNED <u>2/26/71</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>HOORAZAR, M.D.</u> DEGREE | | | | 23D. ADDRESS <u>Sinai hospital, Balto Md. 21215</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24B. DATE <u>2-28-71</u> | 24C. NAME of CEMETERY or CREMATORY <u>ANSHE EMUNAH</u> | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jabel, M.D.</u> | 25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

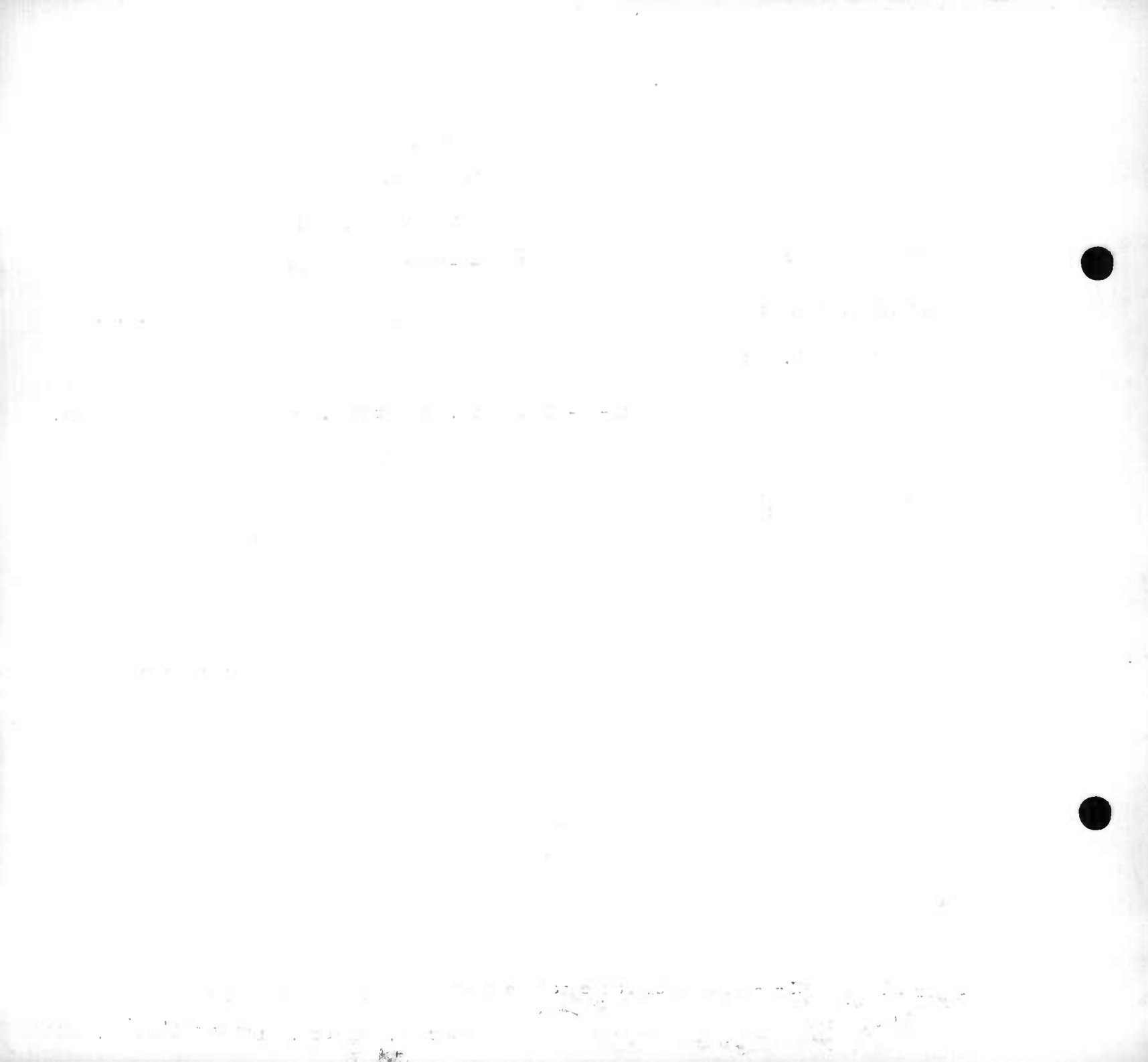
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2137</u> | |
|--|--|--|--|---|--|
| C400 | | 71 2137 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| COLE, Harry | | 3/1/71 5:55 A.M. | | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | |
| Sinai Hospital of Baltimore 2 Baltimore Id. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland Baltimore 5300 | | C. CITY OR TOWN Baltimore | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 12-12-1903 | | 9. AGE (In years last birthday) 67 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME PHILIP COLE | |
| 14. MOTHER'S MAIDEN NAME SOPHIE ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MRS. MARTHA COLE, 3405 DEEP WILLOW AVENUE #8 | | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 12/13/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED peripheral vascular disease 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 1/21/71 to 3/1/71 that (I) (we) last saw the deceased alive on 3/1/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE H. LEVEQUE 23B. DATE SIGNED 3/1/71 23C. PHYSICIAN'S NAME (Type) H. LEVEQUE 23D. ADDRESS Sinai Hospital of Baltimore 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 3-2-71 24C. NAME OF CEMETERY or CREMATORY NEW HAR SINAI 24D. LOCATION (City, town, or county) (State) OWINGS MILLS, MD. 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 25B. NAME OF REGISTRAR Robert E. Talley, M.D. 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2138</u> | |
|--|------------------|---|--|--|---|
| BIRTH NO. <u>71 2138</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>THOMAS E. MANION</u> | | | 2. DATE AND HOUR OF DEATH <u>3/2/71</u> <u>5:52 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland Grl. Hosp.</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1702</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1214 Eutaw Place</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-4-1900</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Dennis P. Manion</u> | | | 14. MOTHER'S MAIDEN NAME <u>Johanna Flynn</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>212-14-8138A</u> | | |
| 17. INFORMANT <u>Mrs. Margaret M. McCubbin, 1117 Scott St.</u> | | | ADDRESS <u>21230</u> | | |
| 18. <u>43691</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RUIM. EDEMA</u> <u>Renal Failure</u> <u>Aspiration Pneum.</u> <u>STROKE</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u> <u>2 WKS</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that he (this hospital) attended the deceased from <u>2/17</u> 19 <u>71</u> to <u>3/2</u> 19 <u>71</u> that he (we) last saw the deceased alive on <u>3/2</u> 19 <u>71</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE <u>J. M. Pardo M.D.</u> | | | | 23B. DATE SIGNED <u>3/2/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-5-1971</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 24E. FUNERAL DIRECTOR <u>Howard H. Hubbard</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>4107 Wilkens Ave. 21229</u> | |



71 2139

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2139

BIRTH NO.

| | | | |
|--|---------------|--|--|
| 1. NAME OF DECEASED (Type or Print) Lawrence S. Miller | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 1 Year 71 Hour 12:56 a. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital | | 3. DATE PRONOUNCED DEAD Month 3 Day 1 Year 71 Hour 12:56 a. M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Carroll 5627 | | C. CITY OR TOWN Manchester D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX male | 7. RACE White | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH 1/8/50 | | 10. AGE (In years lost birthday) 21 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver | | 14B. KIND OF BUSINESS OR INDUSTRY Atlas Trans. Co. | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Army Reserves 1971 | | 17. SOCIAL SECURITY NO. 217-50-1477 | |
| 18. INFORMANT Mrs. G. Sterling Miller | | ADDRESS Westminster RD#5 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) BLDG. 4 | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Atlas Transportation Company- Dundalk | | 22D. HOW DID INJURY OCCUR? Pedestrian hit by fork lift truck. | |
| 22D. TIME OF INJURY (APPROX.) 2 24 71 11:00a | | 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type): Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: 3/1/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/3/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Kriders Cemetery | | 24D. LOCATION (City, town, or county) (State) Westminster-Carroll Co.-Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR J. J. Zupers, Jr. - Westminster, Md. | | ADDRESS 21157 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2140</u> | |
|---|-------------------------|---|--|---|---|
| 042071 2140 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>GEORGE FRANCIS OLESH</u> | | 2. DATE AND HOUR OF DEATH <u>2-26-71</u> <u>1:10 P.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>NORTH CHARLES GEN. HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>BALTIMORE CITY</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>116 N. ROSE ST.</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-26-1902</u> | 9. AGE in years (last birthday) <u>69</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED (MTA)</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>MTA</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | 13. FATHER'S NAME <u>JOHN OLESH</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>AMELIA WAGNER</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | |
| 16. SOCIAL SECURITY NO. <u>213-05-9168</u> | | 17. INFORMANT <u>Daughter - Rose 6901 East Brehms</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Pulmonary embolism & Dissecting aortic aneurysm</u> | | CAUSE OF DEATH <u>CARCINOMA - Lungs</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | <u>red myocardial infarct, @ ventricular heart</u> | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>pyelonephritis</u> | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> <u>NO</u> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) Month: Day: Year: Hour: Min. | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-18</u> 19 <u>71</u> to <u>2-26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>2-26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Emmanuel M. Maniago</u> | | M.D. DEGREE <u>EMMANUEL M. MANIAGO</u> | | 23B. DATE SIGNED <u>2-26-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>EMMANUEL M. MANIAGO</u> | | 23D. ADDRESS <u>North Charles Gen. Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>3/2/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> | |
| 24D. LOCATION <u>Balto., Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc., 3331 Brehms Lane, Balto., Md. 21213</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 2141

| | | | |
|--|--|---|--|
| BIRTH NO. Z 1271 2141 | | ZEBACK | |
| 1. NAME OF DECEASED (Type or Print) PETER ZEBACK | | 2. DATE AND HOUR OF DEATH Feb. 27, 1971 9:20 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2605 | |
| 5. SEX Male | | 6. RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/2/99 | |
| 9. AGE (In years last birthday) 71 | | 10. Under 1 Yr. Months Days If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) elevator mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY Johns Hop. Hosp. | |
| 11. BIRTHPLACE (State or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unk | | 14. MOTHER'S MAIDEN NAME UNK | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I | | 16. SOCIAL SECURITY NO. 205-03-3900A | |
| 17. INFORMANT BCH Records: | | ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224 | |
| 18. 4-86X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMBOLUS (B) DUE TO, OR AS A CONSEQUENCE OF: COPD EMPHYSEMA (C) Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 2/14 19 71 to 2/27 19 71 that (1) (we) last saw the deceased alive on 1/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE J R Wands DEGREE | | 23B. DATE SIGNED 2/27/71 | |
| 23C. PHYSICIAN'S NAME (Type) J R Wands DEGREE | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Balto., Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 3/3/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4, 1971 | | 25B. NAME OF REGISTRAR Robert E. Hall | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Home Inc., 3331 Brehms Lane, Balto., Md. 21213 | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 71 2142 | |
|---|--|---|--|--|--|--|--|
| BIRTH NO. 71 2142 | | | | 1. NAME OF DECEASED (Type or Print) ANNA MARY LOANE | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH 2-27-71 140 P.M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland , B. COUNTY Baltimore | | C. CITY OR TOWN Baltimore | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-3-22 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (in years last birthday) 48 | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Walter J. Hamburg | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 217-12-6468 | | 17. INFORMANT BCH-Records ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 172914-23019 Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Diabetes mellitus | | | | (A) IMMEDIATE CAUSE Malignant melanoma DUE TO, OR AS A CONSEQUENCE OF: 4 mos. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: 3 years. | | | |
| 19A. DATE OF OPERATION 2/21 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/21 19 71 to 2/27 19 71 that (I) (we) last saw the deceased alive on 2/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Robert H. Creech, MD. DEGREE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-27-71 | |
| 23C. PHYSICIAN'S NAME (Type) Robert H. Creech MD. DEGREE | | | | 23D. ADDRESS BCH- Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 3/3/71 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, R.D. | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc., 3331 Brehms Lane, Balto., Md. 21214 | | ADDRESS | |

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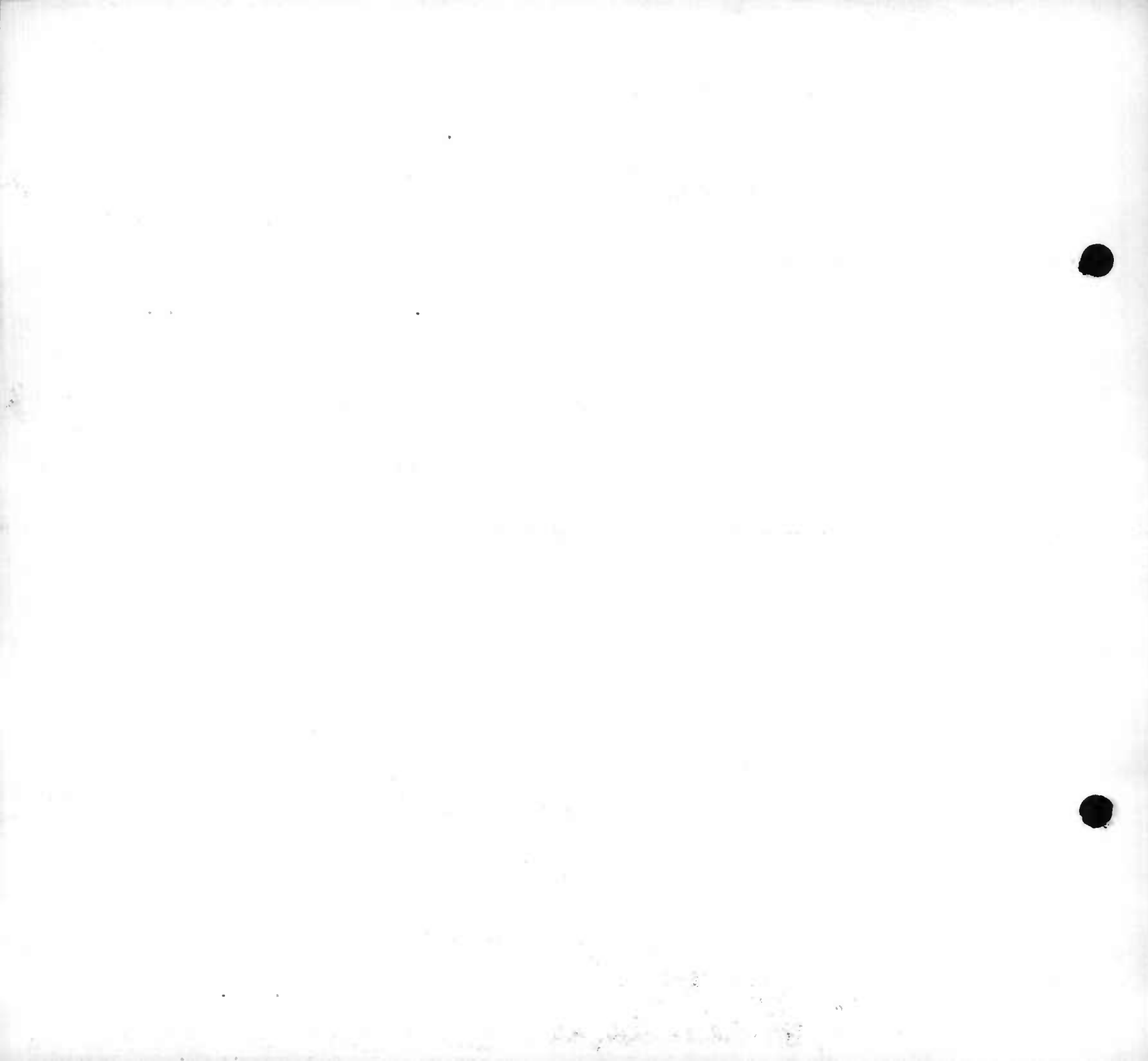
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2143</u> | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. <u>540071 2143</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>FLORENCE A. Sewell</u> | | | 2. DATE AND HOUR OF DEATH <u>2/27/71</u> <u>8:00 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Key Circle Hospice</u> <u>1214 Eutaw Place</u> <u>BALTO. Md. 21217</u> | | | A. STATE <u>Md.</u> B. COUNTY <u>2643</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN <u>BALTO.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER <u>3739 Ravenwood Ave.</u> <u>21213</u> | | | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/16/89</u> | 9. AGE (In years last birthday) <u>81</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Balto.</u> | |
| 13. FATHER'S NAME <u>JONATHAN BURTON</u> | | 14. MOTHER'S MAIDEN NAME <u>Rachel ENSORE</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>217-48-6046</u> | | 17. (INFORMANT ADDRESS) <u>Helen Dobrzykowski</u> <u>3739 Ravenwood Ave.</u> <u>BALTO. Md. 21213</u> | |
| 18. <u>4/12/31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE <u>ASACD Cong. Heart failure days</u> DUE TO, OR AS A CONSEQUENCE OF: <u>arteriosclerotic heart disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Flummaroid Arthritis, urinary tract infection</u> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>2 27 71 8:00 AM</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> <u>1969</u> to <u>2/27</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>2/11</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Dionisio Garcia Jr. M.D.</u> | | | | 23B. DATE SIGNED <u>2/27/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DIONISIO GARCIA JR. M.D.</u> | | | | 23D. ADDRESS <u>5550 BALTO. NAT. PIKE, MD. 21228</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>3/2/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u> | |
| 24D. LOCATION <u>Balto., Md.</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | | |
| 25A. NAME OF REGISTRAR <u>Robert E. Talley, Jr.</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Talley, Jr.</u> | | 25C. FUNERAL DIRECTOR <u>Schimmerek Funeral Home</u> | |
| 25D. ADDRESS <u>3331 Brehms Lane, Balto., Md. 21213</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 2144</u> | |
|---|-------------------------|---|-------------------------------------|---|--|---|---|
| BIRTH NO. <u>1364</u> <u>2144</u> | | | | 2. DATE AND HOUR OF DEATH <u>MARCH 2, 1971</u> <u>3:00P</u> M. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>ITTER, ANNA M</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>19 HOLMES AVE 21228</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>04/26/13</u> | 9. AGE (In years last birthday) <u>57</u> | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Hecht Co.</u> | | 13. FATHER'S NAME <u>WILLIAM ROLF</u> | | 14. MOTHER'S MAIDEN NAME <u>ALICE (MC MULLEN) ROLF</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u> | | 16. SOCIAL SECURITY NO. <u>218-03-3605</u> | | 17. INFORMANT ADDRESS <u>ST. AGNES HOSPITAL RECORDS</u> | | | |
| 18. <u>73401</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) IMMEDIATE CAUSE <u>CHRONIC RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ESCLERODERMA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 month</u> <u>2 years</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1</u> 19 <u>71</u> to <u>MARCH 2</u> 19 <u>71</u> that (i) (we) last saw the deceased alive on <u>MARCH 2</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | 23B. DATE SIGNED <u>3.2.71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>CARLOS ROZENBOM</u> | |
| 23D. ADDRESS <u>St. Agnes Htal</u> | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 24B. DATE <u>3/6/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Tabor, R.D.</u> | | 25C. FUNERAL DIRECTOR <u>Witzke</u> | | ADDRESS <u>1830 Edmondson Ave 21228</u> | |

1. $E^2 = P^2 + M^2$ \Rightarrow $E = \sqrt{P^2 + M^2}$

2. $\vec{P} = \vec{p} + \vec{p}'$

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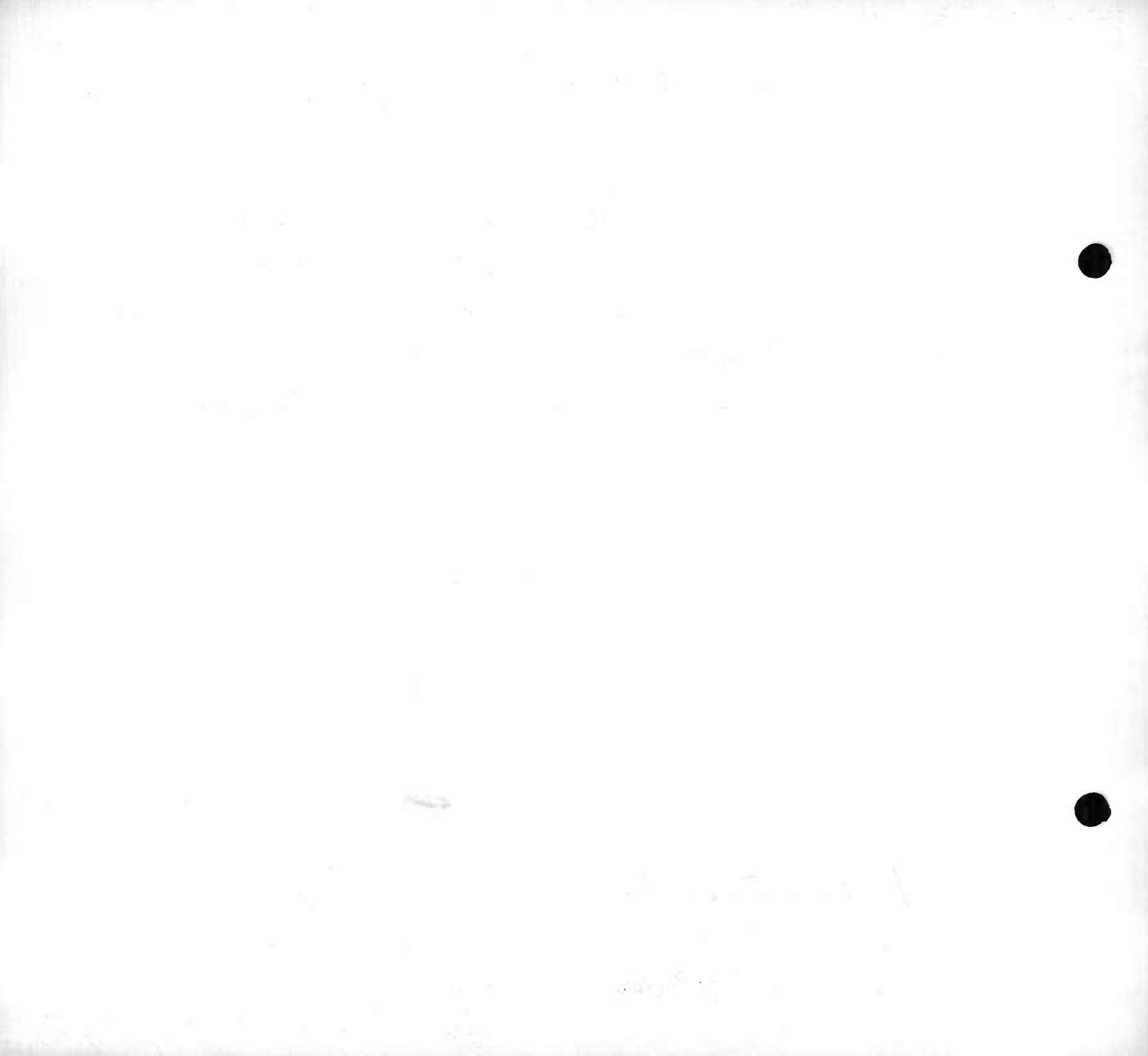
22. $\vec{p} = \vec{p} + \vec{p}'$

23. $\vec{p} = \vec{p} + \vec{p}'$

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

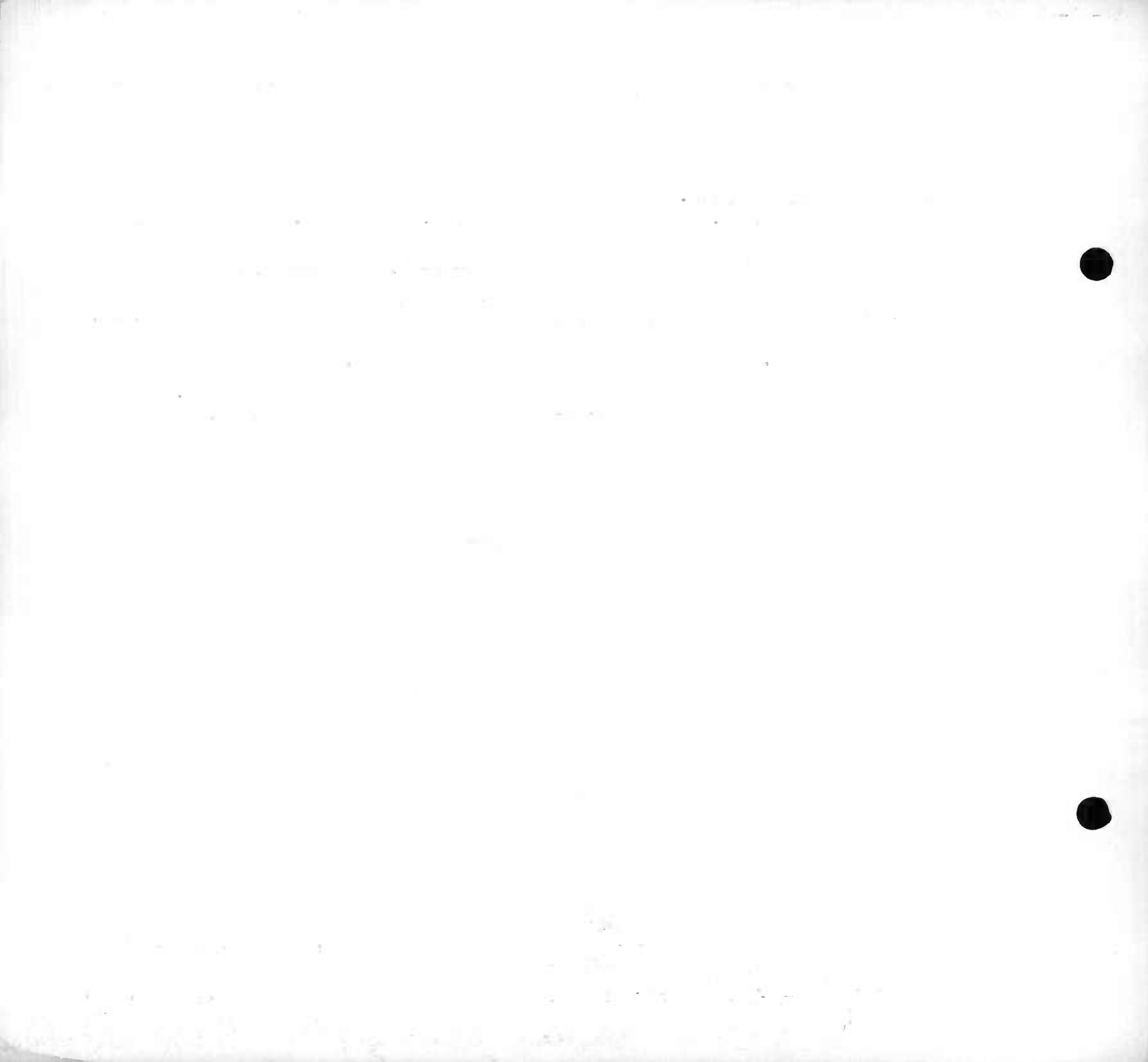
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 58-55-06 | |
|---|----------------------|---|---|
| S 3473 2145 | | 71 2145 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) GEORGE F. STOLTE | | 2. DATE AND HOUR OF DEATH 3/2 1971 3:15 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224 | | A. STATE MARYLAND | |
| | | C. CITY OR TOWN BALTIMORE | |
| | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 3226 O'DONNELL STREET 21224 | |
| 5. SEX male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-22-14 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY REVERE BRASS & COPPER | 9. AGE (in years last birthday) 56 yrs |
| 13. FATHER'S NAME FREDERICK STOLTE | | 14. MOTHER'S MAIDEN NAME Mary REISIG | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 214-03-0929 | |
| | | 17. INFORMANT 4940 Eastern Avenue ADDRESS BCH: Records Baltimore, Maryland 21224 | |
| 18. 4/10/91 CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | Cardiogenic Shock 24 Hours | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES | | Acute Myocardial Infarction 36 Hours | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) Arteriosclerotic Vascular Disease | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 21G. INJURY OCCURRED | | 21H. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/1 1971 to 3/2 1971 that (I) (we) last saw the deceased alive on 3/1 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE John M. Amatruda MD | | 23B. DATE SIGNED 3/2/71 | |
| 23C. PHYSICIAN'S NAME (Type) John M. Amatruda MD | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-5-71 | |
| 24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM. | | 24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD, BA, CO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. 1971 000 | | 25B. NAME OF REGISTRAR Charles S. Gailer | |
| | | 25C. FUNERAL DIRECTOR ADDRESS 901 S. CONKLING ST, BALTO, 21224, MD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2146 | |
|---|---------------|--|--------------------------|--|--|
| BIRTH NO. R 4091 2146 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Elizabeth Riehl | | 2. DATE AND HOUR OF DEATH 3/1/71 6:22 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224 | | 4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 631 S. Potomac St. 21224 007 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-17-87 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY House Work | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13. FATHER'S NAME Casper J. Riehl | | 14. MOTHER'S MAIDEN NAME Mary E. Bieker | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-30-5911 | | 17. INFORMANT 4940 Eastern Ave. BCH Records: Baltimore, Md. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 436.9 I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (2) CVA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Urinary Tract Infection | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 3/1/71 to 3/1/71 that (H) (we) last saw the deceased alive on 3/1/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Russell Harris, M.D. | | 23B. DATE SIGNED 3/1/71 | | 23C. PHYSICIAN'S NAME (Type) Russell Harris M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-5-71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION 4430 Belair Rd., Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | |
| 25C. FUNERAL DIRECTOR Charles J. Geiler | | 25D. ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2147

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MICHAEL E. McCRAY

2. DATE
OF
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☐

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

37 MERCY HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

March 2, 1971

7:05 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

1504

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

21.53

10. AGE (in years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1912 McKean Avenue

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James M. McCray

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Geraldine Turner

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

CAUSE OF DEATH

Gunshot wound of head

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

?

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Balto. and Harrison Streets

401

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

2-28-71 2:30 A.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot by unknown assailant

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/3/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24, 71

24C. NAME OF CEMETERY or CREMATORY

Arboretum

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 4 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

1305 W. ...

ACADEMY BOUND

05/24/40 57 80
VENABLE, Nannie
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

| | | | | | |
|---|------------------|---|-----------------------------|---|---|
| V514771 2148 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2148 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | VENABLE, Nannie | | 3/3/71 7:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | A. STATE Maryland | | B. COUNTY 1002 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 921 McAleer Ct. | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/23/26 | 9. AGE (In years last birthday) 45 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY | | 13. FATHER'S NAME Junius Venable | | 14. MOTHER'S MAIDEN NAME Maude Knight | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT James Venable - 1115 2nd St. Ct. | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC NECROSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ? I N H | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 Nov | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/25 1971 to 3/3 1971 that (II) (we) last saw the deceased alive on 3/3 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Stephen T. Miller M.D. | | 23B. DATE SIGNED 3/3/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Stephen T. Miller, M.D. | | The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-71 | | 24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem. | |
| 24D. LOCATION (City, town, or county) (State) A. A. County Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Elmer J. Turner | | 25D. ADDRESS 11297 Condit St. | | | |

10/26/71 Cause of Death
Hepatic necrosis
INIT

relating TB / Letter from
JNH filed in
Bureau of Biostatistics

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 2149 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2149 | |
|--|------------------|--|-----------------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) <u>Lloyd B. Wells</u> | | 2. DATE AND HOUR OF DEATH <u>March 1, 1971</u> <u>6:55</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hosp</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>E</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2306 Barclay St.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/2/14</u> | 9. AGE (in years last birthday) <u>57</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13. FATHER'S NAME <u>Lloyd B. Wells Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Johnson</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Bertha Skelley</u> ADDRESS <u>1329 N. Lenthall Ave.</u> | |
| 18. <u>442X1</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>2/26</u> (3/1) 19 <u>71</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bilateral Femoral Fractures</u> 19C. AUTOPSY? (Yes or No) <u>(Yes)</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> 19 <u>71</u> to <u>3/1</u> 19 <u>71</u> thor (I) (we) last saw the deceased alive on <u>3/1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>Omar D. Crothers III</u> MD DEGREE 23B. PHYSICIAN'S NAME (Type) <u>Omar D. Crothers III</u> MD DEGREE 23C. ADDRESS <u>Union Memorial Hosp</u> 23D. DATE SIGNED <u>3/1/71</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>3-5-71</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u> 24D. LOCATION (City, town, or county) (State) <u>Spesport, Md.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> 25B. NAME OF REGISTRAR <u>Robert E. Spelley, Jr.</u> 25C. FUNERAL DIRECTOR <u>Elizeth General Home</u> ADDRESS <u>112 17 N. Parkway</u> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2150 | |
|--|---------------------|--|--------------------------------------|---|---|
| 71 2150 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Elliott, Jessie V.</i> | | 2. DATE AND HOUR OF DEATH <i>2-27-71 9:30p</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1101</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Key Circle Hospice</i> | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <i>1214 Eutaw Place</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9-20-1875</i> | 9. AGE (in years last birthday) <i>95</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Akres, Samuel</i> | | 14. MOTHER'S MAIDEN NAME <i>Cooper, Katreah</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-01-86920</i> | | 17. INFORMANT <i>Holland, Mildred E.</i> | |
| 18. <i>4/2/31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>arteriosclerotic heart disease</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>same</i> | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>chronic brain syndrome, senile</i> | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If in Baltimore City, give exact location) <input type="checkbox"/> <i>Notify medical examiner</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>2 27 71 9:30p</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>10/8 1970</i> to <i>2/27 1971</i> that (I) (we) last saw the deceased alive on <i>2/11 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Dionisio Garcia Jr. MD</i> | | 23B. DATE SIGNED <i>2/28/71</i> | | 23C. PHYSICIAN'S NAME (Type) <i>DIONISIO GARCIA JR. MD</i> | |
| 23D. ADDRESS <i>KEY CIRCLE HOSPICE</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/2/71</i> | |
| 24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Co., Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 4 1971</i> | |
| 25B. NAME OF REGISTRAR <i>Robert E. Faber, MD</i> | | 25C. FUNERAL DIRECTOR <i>William A. Johnson</i> | | 25D. ADDRESS <i>8521 Loch Raven Blvd. Baltimore, Md. 21204</i> | |

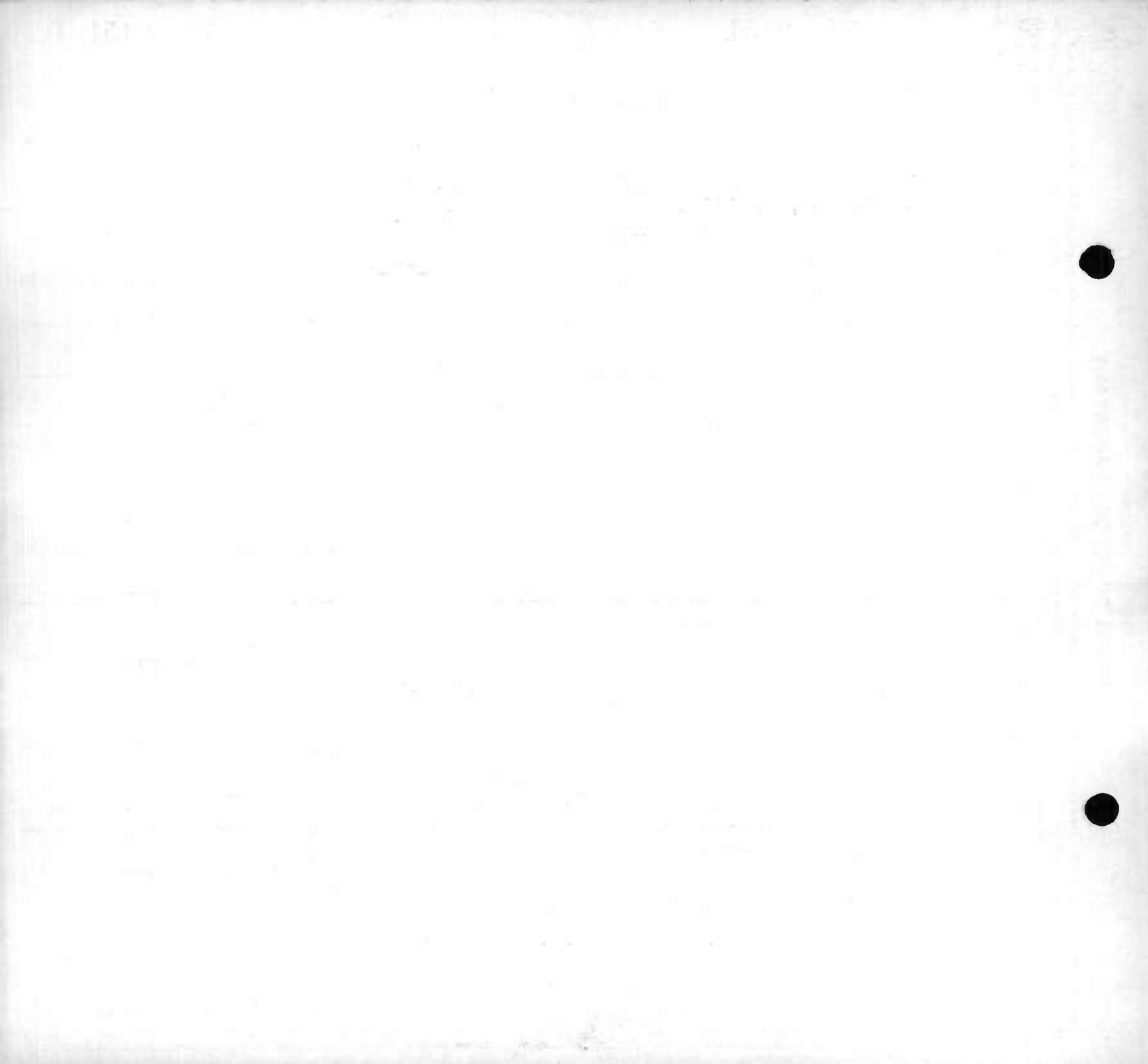
1042 N. CAIVERT ST.

10/1/69

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2151</u> | |
|--|----------------------|---|--------------------------------|--|--|
| BIRTH NO. <u>71 2151</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Thompson, Annie Neal</u> | | 2. DATE AND HOUR OF DEATH <u>3/3/71</u> <u>5¹⁵ A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1001</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>938 E. BIDDLE STREET</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-6-22</u> | 9. AGE (In years last birthday) <u>48</u> | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Clarence Neal</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNIE NEAL</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Ernest Neal 1722 N. Bond St.</u> | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Sepsis</u> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Abdominal Abscess</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>1 wk.</u> | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Dehydration</u> | | | | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/2</u> 19 <u>71</u> to <u>3/3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Stephen T. Miller MD</u> | | 23B. DATE SIGNED <u>3/3/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>STEPHEN T. MILLER M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>3-6-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u> | |
| 24D. LOCATION <u>Laurel, Maryland</u> | | 24E. NAME OF REGISTRAR <u>Marshall W. Jones, Jr.</u> | | 24F. FUNERAL DIRECTOR <u>1735 Harford Ave. AD 1153</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | 25B. NAME OF REGISTRAR <u>Marshall W. Jones, Jr.</u> | | 25C. FUNERAL DIRECTOR <u>1735 Harford Ave. AD 1153</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2152 | |
|---|--|---|--|--|---|
| BIRTH NO. 71 2152 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MARGARET SHEA | | | 2. DATE AND HOUR OF DEATH 3/2/71 4³⁰ P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 GOULD NURSING HOME 6116 BELAIR ROAD | | | A. STATE MARYLAND B. COUNTY 903 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX FEMALE | | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK KEEPER | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH JAN 5 1892 |
| 13. FATHER'S NAME JAMES SHEA | | | 14. MOTHER'S MAIDEN NAME KILMAY | | 9. AGE (In years lost birthday) 79 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 215-50-9916 | | 11. BIRTHPLACE (State or foreign country) TEXAS MD |
| 17. INFORMANT MRS DORIS BARRY | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | |
| 18. 4/37/91 | | | ADDRESS 4108 MARY AVE | | |
| 19. CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Multiple Stroke | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: noth. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Brain Syndrome | | | (B) Arteriosclerotic Cerebrovascular Disease DUE TO, OR AS A CONSEQUENCE OF: yes | | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Uremia; Renal Disease; Chronic | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/9/71 to 3/2/71 , that (I) (we) last saw the deceased alive on 2/27/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert D. Bradley | | | | 23B. DATE SIGNED 3/2/71 | |
| 23C. PHYSICIAN'S NAME (Type) DEGREE | | | | 23D. ADDRESS DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2-5-71 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEM | |
| 24D. LOCATION EDMONDSON AVE | | 24E. (City, town, or county) BALTO MD | | 24F. (State) BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 4 1971 | | 25B. NAME OF REGISTRAR Robert E. Kelly | | 25C. FUNERAL DIRECTOR Eric Greif (Cob) 7200 Hayford Road | |

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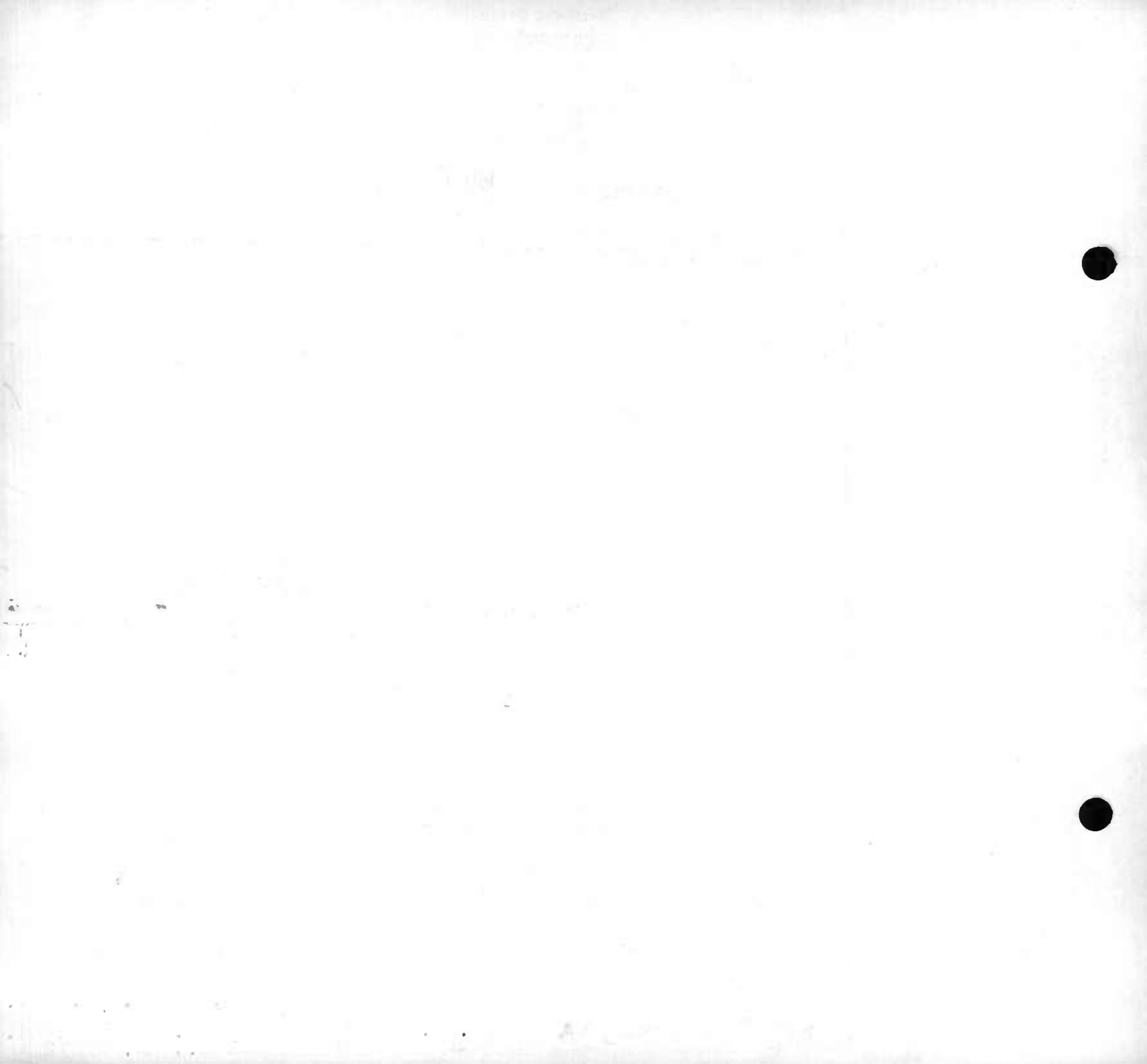
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

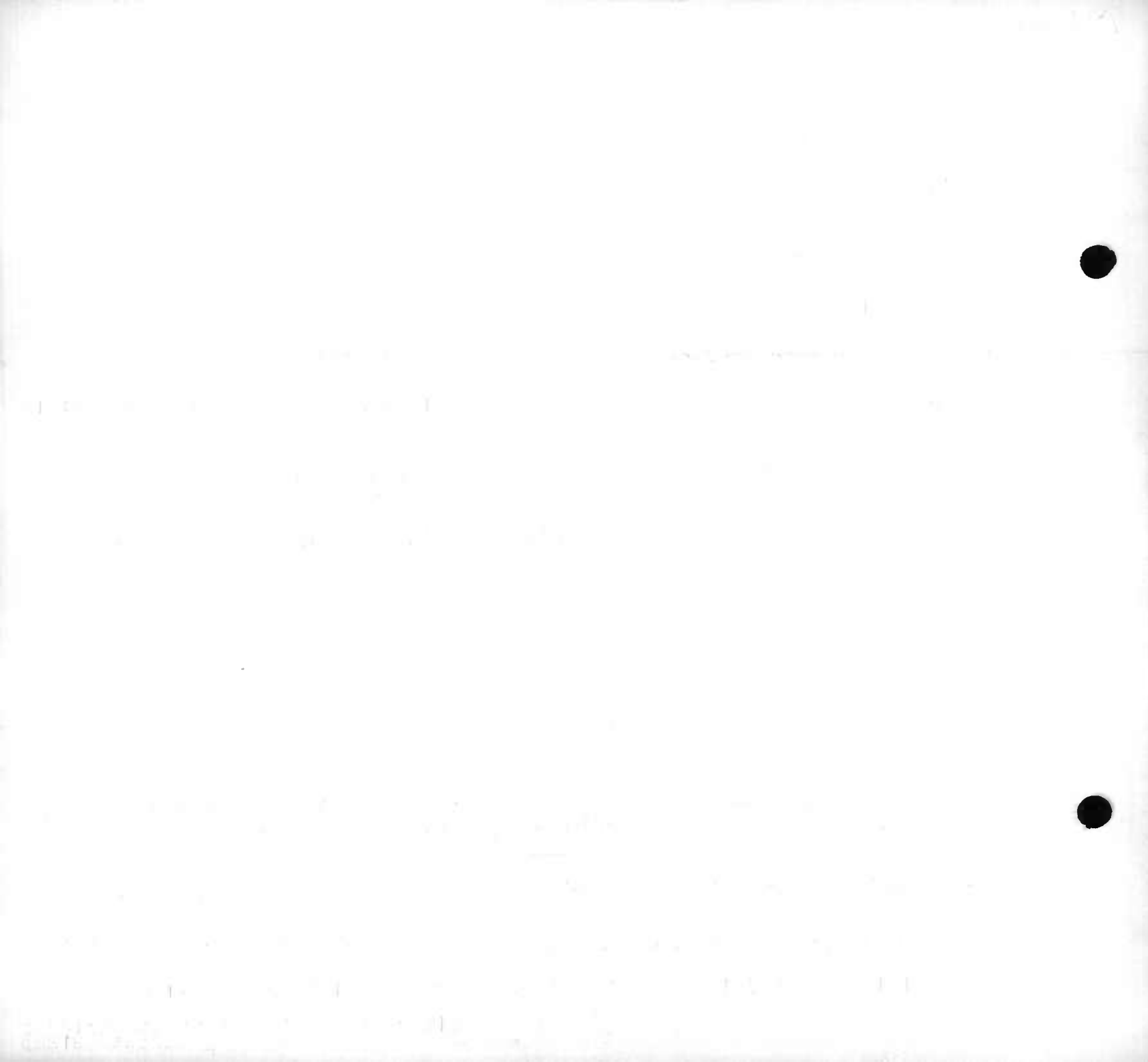
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2153</u> | |
|---|-----------------------------|---|--|---|---|
| 71 2153 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. <u>71 2153</u> | | | 2. DATE AND HOUR OF DEATH <u>3/3/71</u> <u>10 05</u> A.M. | | |
| 1. NAME OF DECEASED (Type or Print) <u>GRACE B. MORGAN</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1401</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION MEMORIAL HOSPITAL</u> | | | C. CITY OR TOWN <u>BALTO. CITY</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1529 BOLTON STREET</u> | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>CAUCASIAN</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-6-98</u> | 9. AGE (In years last birthday) <u>72</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN - REAL ESTATE</u> | | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>JAMES CLARENCE BUSEY</u> | | | 14. MOTHER'S MAIDEN NAME <u>MARY WATERS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>65 236077</u> | | 17. INFORMANT <u>MRS. BARBARA CUSHING</u> ADDRESS <u>1407 PARK AVE, BALTO.</u> |
| 18. <u>486X1</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> | | |
| (A) IMMEDIATE CAUSE <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: | | | <u>5 YRS</u> | | |
| (B) <u>CHRONIC LUNG DISEASE, ETIOLOGY UNKNOWN</u> DUE TO, OR AS A CONSEQUENCE OF: | | | <u>20 YRS (R.A.)</u> | | |
| (C) <u>RHEUMATOID ARTHRITIS, UNKNOWN</u> <u>ARTERIOSCLEROTIC HEART DISEASE with congestive heart failure</u> | | | <u>unknown</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> 19 <u>71</u> to <u>3/3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1/20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>David J. Powner, MD</u> | | | 23B. DATE SIGNED <u>3/3/71</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. DAVID J. POWNER</u> | | | 23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/5/71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u> | | 24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 4 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd. Balto., Md. 21212</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2154 | |
|---|----------------------|---|------------------------------------|---|---|
| BIRTH NO. 71 2154 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Dora Myers</u> | | 2. DATE AND HOUR OF DEATH <u>3-2-71</u> <u>12 noon</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Ashburton House Inc</u> <u>3520 W. Hilton Rd.</u> <u>Baltimore, Md</u> | | A. STATE <u>Md</u> | | B. COUNTY <u>1401</u> | |
| | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>1615 Park Ave</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>Wh</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-26-84</u> | 9. AGE (in years last birthday) <u>86</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>-----Myers</u> | | 14. MOTHER'S MAIDEN NAME <u>-----</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-56-2685</u> | | 17. INFORMANT ADDRESS <u>Ethel Myers 2826 Kentucky Ave. 21213</u> | |
| 18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>unknown</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 6</u> 19 <u>69</u> to <u>March 2</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>March 1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Abraham B. Hurwitz MD</u> | | | | 23B. DATE SIGNED <u>March 7, 1971</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ABRAHAM B. HURWITZ MD</u> | | 23D. ADDRESS <u>7501 Liberty Rd. Baltimore, Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/4/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 5 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Walters Funeral Home Pratt & Stricker Streets 21223</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2155 | |
|---|------------------|---|--|---------------------------------------|--|
| 71 2155 | | | | | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) John Ward Keller | | | 2. DATE AND HOUR OF DEATH February 28, 1971 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4816 Gwynn Oak Avenue | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4816 Gwynn Oak Avenue 21207 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-30-1907 | 9. AGE (in years last birthday) 63 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic -retired | | | 11. BIRTHPLACE (State or foreign country) Pikesville, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME John Henry Ward Keller | | | 14. MOTHER'S MAIDEN NAME Catherine E Shipley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 212-03-6948 | | 17. INFORMANT Sarah H. Keller-4816 Gwynn Oak Avenue |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | CAUSE OF DEATH Bilateral Bronchial Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Obstructive Airway Disease (B) Pulmonary Emphysema. (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks. Years. |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 2/27/71 19 to 2/27 19 71 that (I) (we) last saw the deceased alive on 2/28 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Herman Brecher M.D. | | | 23B. DATE SIGNED 3/1/71 | | 23C. PHYSICIAN'S NAME (Type) Herman Brecher M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 3-3-71 | | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Armocost Funeral Chapel-4600 Liberty Hts |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | 25D. ADDRESS Armocost Funeral Chapel-4600 Liberty Hts | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

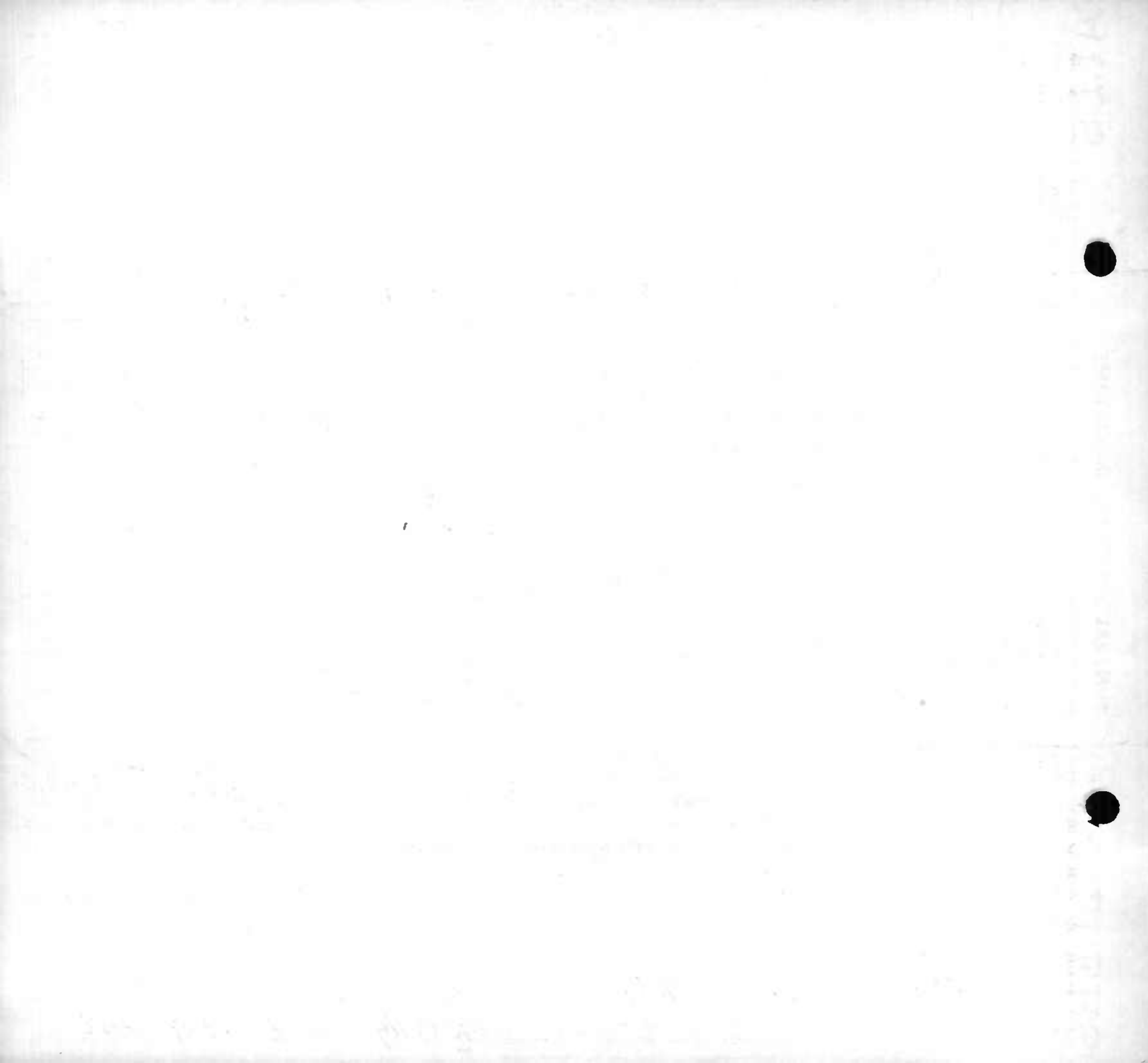
| Baltimore City Health Department | | | | REG. NO. 71 2156 | |
|--|--|---|---|--|--|
| BIRTH NO. 71 2156 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>BURRIS, Michael Gerald</u> | | | 2. DATE AND HOUR OF DEATH <u>2/27/71</u> <u>3:00</u> P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2719</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>North Charles General Hospital</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> # <u>21215</u> | |
| 5. SEX <u>Male</u> | | 6. RACE <u>White</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/2/49</u> | | 9. AGE (in years last birthday) <u>21 YRS.</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 13. FATHER'S NAME <u>MARVIN BURRIS</u> | | 14. MOTHER'S MAIDEN NAME <u>Betty BURRIS</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Marvin G. Burris 5724 Winner Ave. CHART</u> <u>North Charles General Hospital</u> | |
| 18. <u>486X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Phenylketonuria</u> | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>21 yrs</u> | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-17</u> 19 <u>71</u> to <u>Feb 27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Feb 27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>M. H. Kelemen</u> | | | 23B. DATE SIGNED <u>2-27-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>M. H. KELEMEN</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>3-2-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 5 1971</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Fabel</u> | | 25C. FUNERAL DIRECTOR <u>Armados Funeral Chapel-4600 Liberty Hgts</u> |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | | 25D. ADDRESS <u>Armados Funeral Chapel-4600 Liberty Hgts</u> | | |

5724 Winner Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2157 | | | |
|--|--------------|---|----------------------------|---|-----------------------------|---|-----------------------------|
| BIRTH NO. 71 2157 71-03438 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Girl Hay | | | | 2. DATE AND HOUR OF DEATH 3/2/71 5:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY -1052 BRISTOL PLACE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore Gen Hosp. 43 | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER Born @ 428 P.M. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/2/71 | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | 12. CITIZEN OF WHAT COUNTRY |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balt. Md. | | 12. CITIZEN OF WHAT COUNTRY | |
| 13. FATHER'S NAME Ronald Hay | | | | 14. MOTHER'S MAIDEN NAME Donna Hissett | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mother 1052 Bristol Place Balt. 21225 | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 266.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH Card around neck tightly X2 Neonatal Asphyxia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Breech Presentation (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Weeks | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/2 1971 to 3/2 1971 that (I) (we) last saw the deceased alive on 3/2 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John A. Eaddy M.D. OFCER | | | | 23B. DATE SIGNED 3/2/71 | | 23C. PHYSICIAN'S NAME (Type) John A. Eaddy M.D. OFCER | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3/4/71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cem. | | 24D. LOCATION (City, town, or county) Baltimore - Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR McGilly 130 E. Fort Ave | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

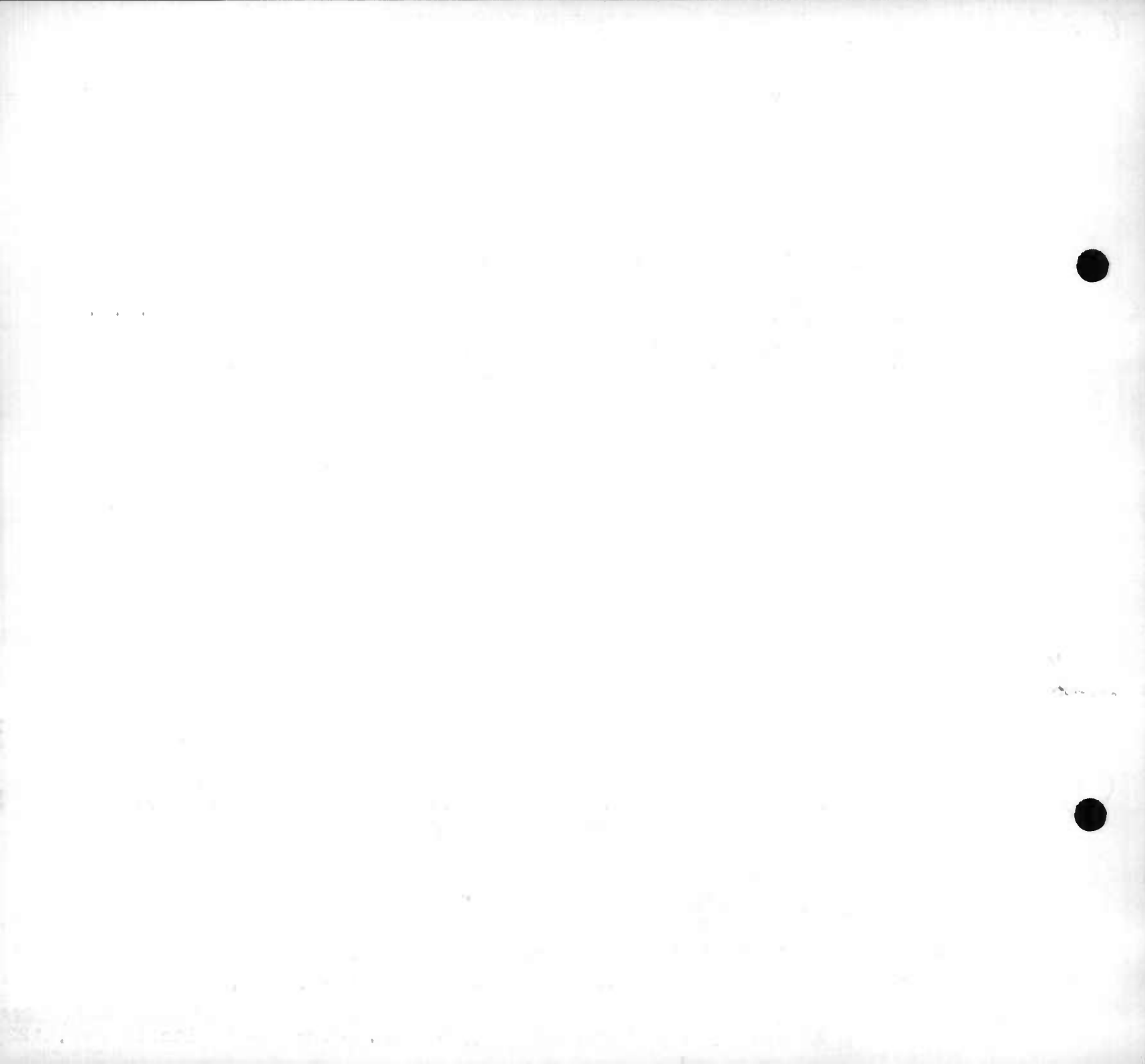
| | | | | | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 71 2158 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2158 | |
| 1. NAME OF DECEASED (Type or Print) HERBERT F. VOLKER. | | | 2. DATE AND HOUR OF DEATH 2/24/71 644 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1202 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER BLACKSTONE APT'S. 33rd + CHARLES | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/23/94 | 9. AGE (in years lost birthday) 76 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPTICIAN | | | 10B. KIND OF BUSINESS OR INDUSTRY SELF-EMP. | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME FREDERICK VOLKER | | |
| 14. MOTHER'S MAIDEN NAME CAROLINE WERNER | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 578-05-9815 | | | 17. INFORMANT JEANNETTE ADDRESS SAME AS ABOVE | | |
| 18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Rupture of aneurysm of right hypogastric artery | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rupture of aneurysm of right hypogastric artery | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Postam Alghalvi | | |
| | | | (C) Postam Alghalvi | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 2/24 19 71 to 2/24 19 71 that (2) (we) last saw the deceased alive on 2/24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Anne L. Seddy | | | 23B. DATE SIGNED 2/24/71 | | 23C. PHYSICIAN'S NAME (Type) DEGREE |
| 23D. ADDRESS 33rd and CALVERT STS. BALTIMORE MD. | | | 23E. FUNERAL DIRECTOR DEGREE | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-27-71 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 5, 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Barber, M.D. | | 25C. FUNERAL DIRECTOR Galley & Company BTH Catonsville Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|---|---|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | X | | REG. NO. 71 2159 | | | | | |
| BIRTH NO. 71 2159 | | | | | | CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) EDNA CASHdollar | | | | | | 2. DATE AND HOUR OF DEATH 3/1/71 11:23 PM | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD HARBOR VIEW NURSING HOME | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY ADCO. | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HARBOR VIEW NURSING HOME | | | | | | C. CITY OR TOWN BALTO | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 5. SEX FEMALE | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-23-74 | | 9. AGE (in years last birthday) 96 | | 10. Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME WM LANCASTER | | | | | | 14. MOTHER'S MAIDEN NAME SARAH PITCHER | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT CHART | | | | ADDRESS | | | |
| 18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A-S. C. V. Disease | | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A-S. C. V. Disease | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chen Brain Syndrome | | | | | | (C) | | | ? | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/5 19 71 to 3/1/71 19 71 that (I) (we) last saw the deceased alive on 2/23 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 23A. SIGNATURE Joseph S. Blum M.D. | | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 3/1/71 | | | | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM M.D. | | | | | | 23D. ADDRESS 1114 CARVERT ST. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3 MARCH 71 | | 24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | | | 25B. NAME OF REGISTRAR Robert E. Talley, M.D. | | 25C. FUNERAL DIRECTOR George J. Gonce ADDRESS 4001 Ritchie Hwy. 2122 | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

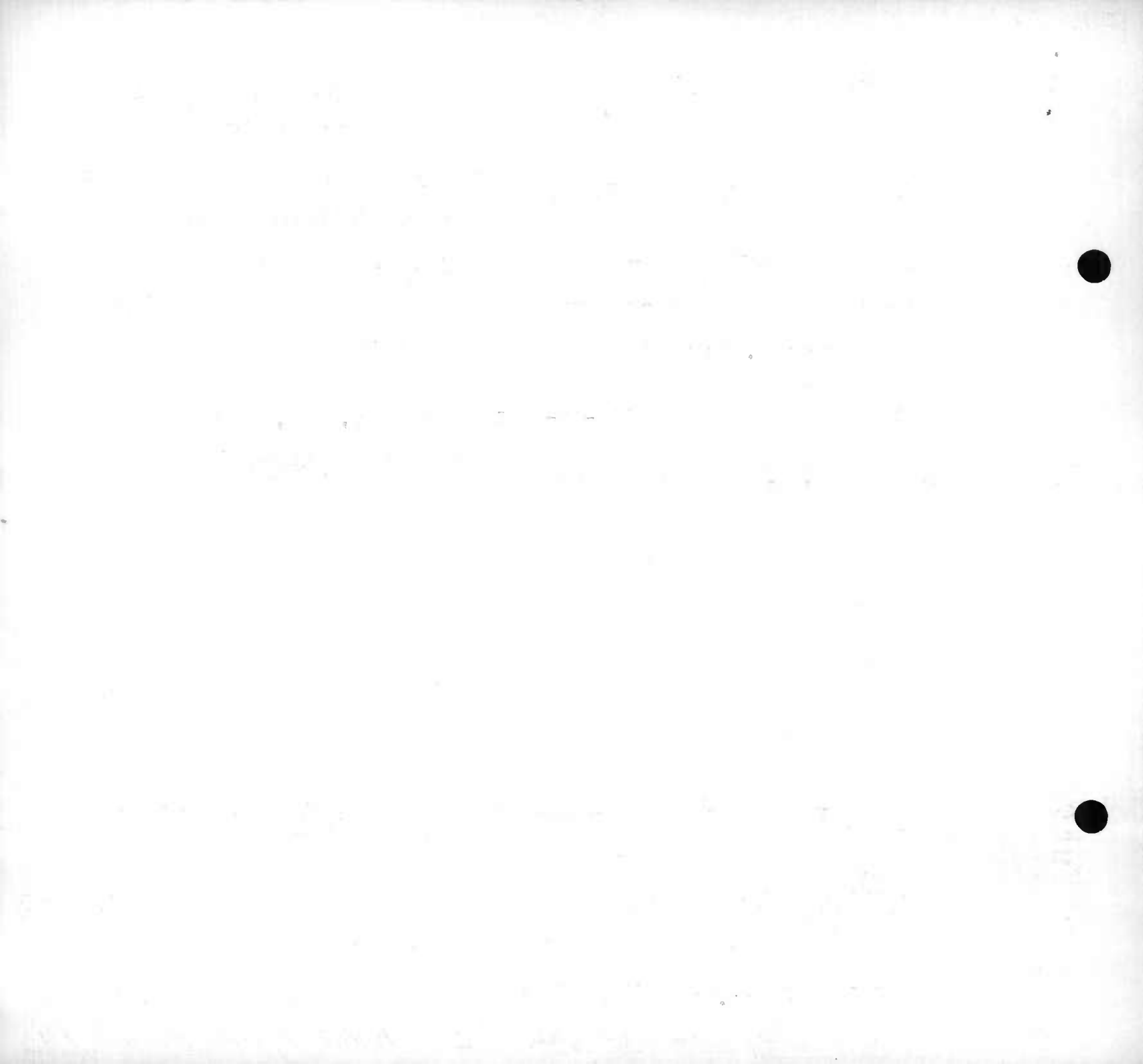
F600

71 2160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 2160

| | | | | | |
|---|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) YVONNE FEAR | | 2. DATE AND HOUR OF DEATH MARCH 3, 1971 11:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY Anne Arundel | | 5. STREET AND NUMBER 8435 MIRMAR ROAD | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. OF BALT. INC. | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN PASADENA | |
| D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | E. STREET AND NUMBER 8435 MIRMAR ROAD | | F. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/21/11 | 9. AGE (In years last birthday) 60 | 10. If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Snack Shop | | 11. BIRTHPLACE (State or foreign country) Canada | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME George T. Guenette | | 14. MOTHER'S MAIDEN NAME Osilea LaPlante | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-10-9291 | | 17. INFORMANT Leo Fear, Son, same as 4 | |
| 18. 20701 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE LEUKEMIA | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (H) (this hospital) attended the deceased from FEB. 23 1971 to MARCH 2 1971 that (H) (we) last saw the deceased alive on MARCH 2 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Dan Sunshine M.D. | | 23B. DATE SIGNED March 2, 1971 | | 23C. PHYSICIAN'S NAME (Type) DAN SUNSHINE M.D. | |
| 23D. ADDRESS SINAI HOSP. OF BALT. INC. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 5 Mar. 71 | |
| 24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE Mem. Pk. | | 24D. LOCATION (City, town, or county) (State) ELKridge, Howard Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | |
| 25B. NAME OF REGISTRAR Robert E. Talbot, M.D. | | 25C. FUNERAL DIRECTOR WICKLEY, Glen Burnie, Md. | | 25D. ADDRESS | |

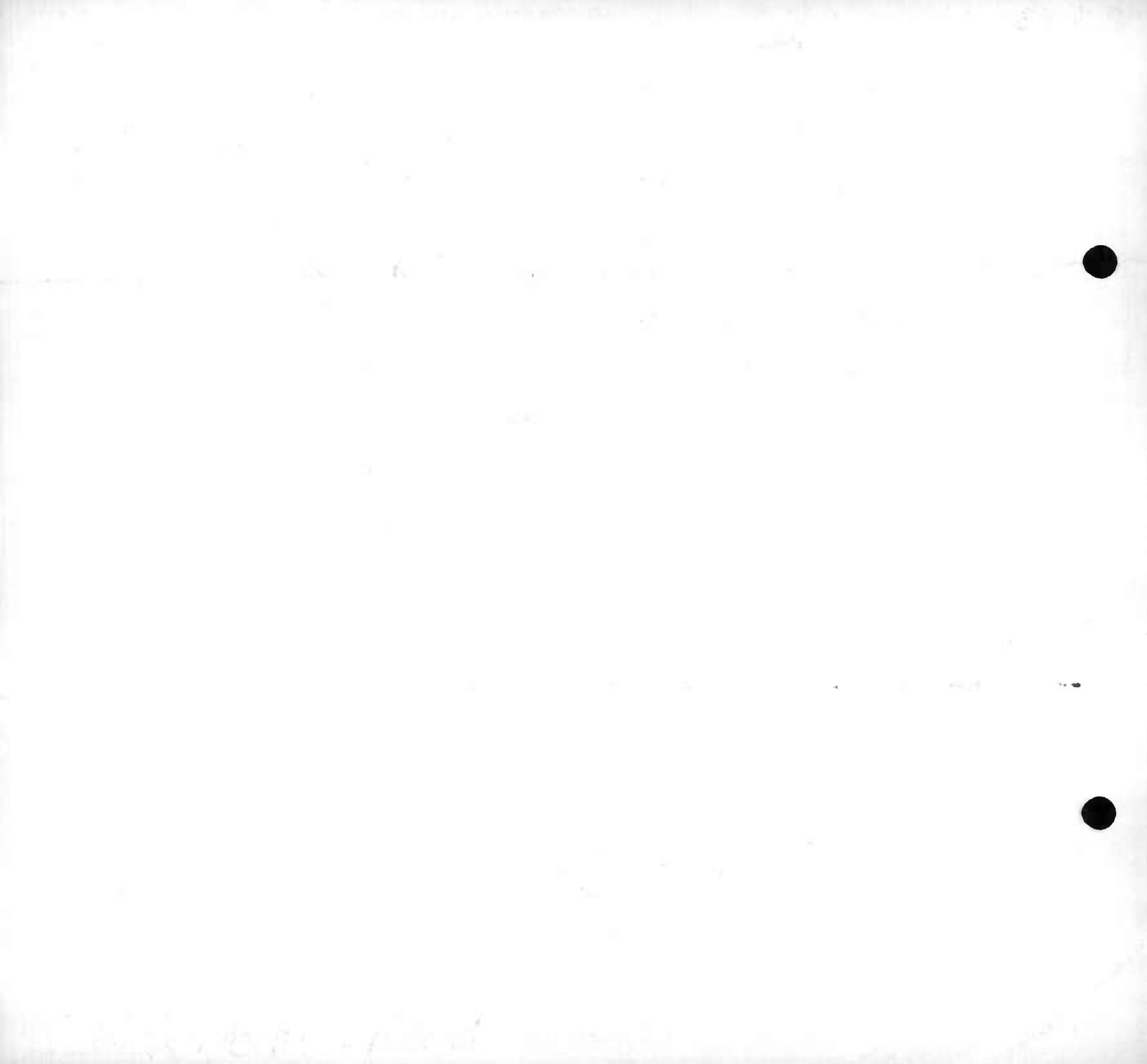


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 71 2161

| | | | |
|--|--|---|--|
| BIRTH NO. 1 71 2161 | | DATE AND HOUR OF DEATH 2/27/71 4AM M. | |
| 1. NAME OF DECEASED (Type or Print) John Christensen | | 2. DATE AND HOUR OF DEATH 2/27/71 4AM M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Md. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY PRINCE GEORGE | |
| 5. SEX male | | 6. RACE WHITE | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-15-98 | |
| 9. AGE (In years last birthday) 72 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICAL THERAPIST HOSPITAL | |
| 11. BIRTHPLACE (State or foreign country) DENMARK | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. 216-P-0734 Chart | |
| 17. INFORMANT | | ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH exact duration unknown | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia | | | |
| (B) Widespread Fungus Infection DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) ASCVD, Chronic brain S-me | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-24-1971 to 2-27-1971 that (I) (we) last saw the deceased alive on 2-27-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE [Signature] | | 23B. DATE SIGNED 2-27-71 | |
| 23C. PHYSICIAN'S NAME (Type) C. GAKUBA | | 23D. ADDRESS 730, ASHBURTON St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-2-71 | |
| 24C. NAME OF CEMETERY or CREMATORY St. Marys Cem. | | 24D. LOCATION (City, town, or county) (State) Laurel Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Talbot, M.D. | |
| 25C. FUNERAL DIRECTOR [Signature] | | ADDRESS [Signature] | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 71 2162 | | | | | X REG. NO. 71 2162 | | | | |
| BIRTH NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) EZRA W. BLANK, Sr. | | | | | 2. DATE AND HOUR OF DEATH 2:10 P.M. 2 MAR 1971 | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIV OF MD HOSP. | | | | | A. STATE MD. B. COUNTY FREDERICK | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | C. CITY OR TOWN FREDERICK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 5. SEX M 6. RACE W | | | | | E. STREET AND NUMBER KEMP LANE, Route 10 | | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH 4-20-13 9. AGE (in years last birthday) 57 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME Chester R. Blank | | | | | 14. MOTHER'S MAIDEN NAME Mary Baker | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. CHART | | | | |
| 17. INFORMANT ADDRESS | | | | | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| LAENNEC'S CIRRHOSIS | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | | | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-23- 19 71 to 3-2 19 71 that (I) (we) last saw the deceased alive on MAR 2 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Sam D. Barlow MD DEGREE | | | | | | | | | |
| 23B. DATE SIGNED 3-2-71 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Sam D. Barlow | | | | | | | | | |
| 23D. ADDRESS Baltimore, Maryland | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE March 5, 1971 | | | | | | | | | |
| 24C. NAME of CEMETERY or CREMATORY Mount Olivet Cemetery 24D. LOCATION (City, town, or county) (State) Frederick Frederick Md. | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | | | | | | | | | |
| 25C. FUNERAL DIRECTOR Donald M. Fitch ADDRESS M. R. Etchison & Son, Frederick, Md. | | | | | | | | | |



71 2163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2163

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mildred McElreath

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

5205 Eastbury St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

3 2 71

11:00 a

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Female

7. RACE

white

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Aug. 3, 1912

10. AGE (In years
last birthday)

58

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

5205 Eastbury St.

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

H. P. Mc Elreath

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Health Exam. Rep.

14B. KIND OF BUSINESS OR INDUSTRY

Government

15. MOTHER'S MAIDEN NAME

Mildred O. Brannon

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. II

17. SOCIAL
SECURITY NO.

255-22-0992

18. INFORMANT

ADDRESS

James H. Mc Elreath Acworth, Georgia

19. CAUSE OF DEATH

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

M.D.

EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

3/2/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

March 4, 1971

24C. NAME OF CEMETERY or CREMATORY

Oak Hill Cemetery

24D. LOCATION (City, town, or county)

Cartersville, Georgia

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 5 1971

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks Towson, Inc. Towson, Md.

ADDRESS 1050 York Rd.

VALLEY SPRING

W. C. DILLON

10 N. 10 E.

THE BODY OF IRVING THOMPSON HAS BEEN RELEASED AS NON MEDICAL BY DR KORNBLUM

FUNERAL DIRECTOR: IMPORTANT

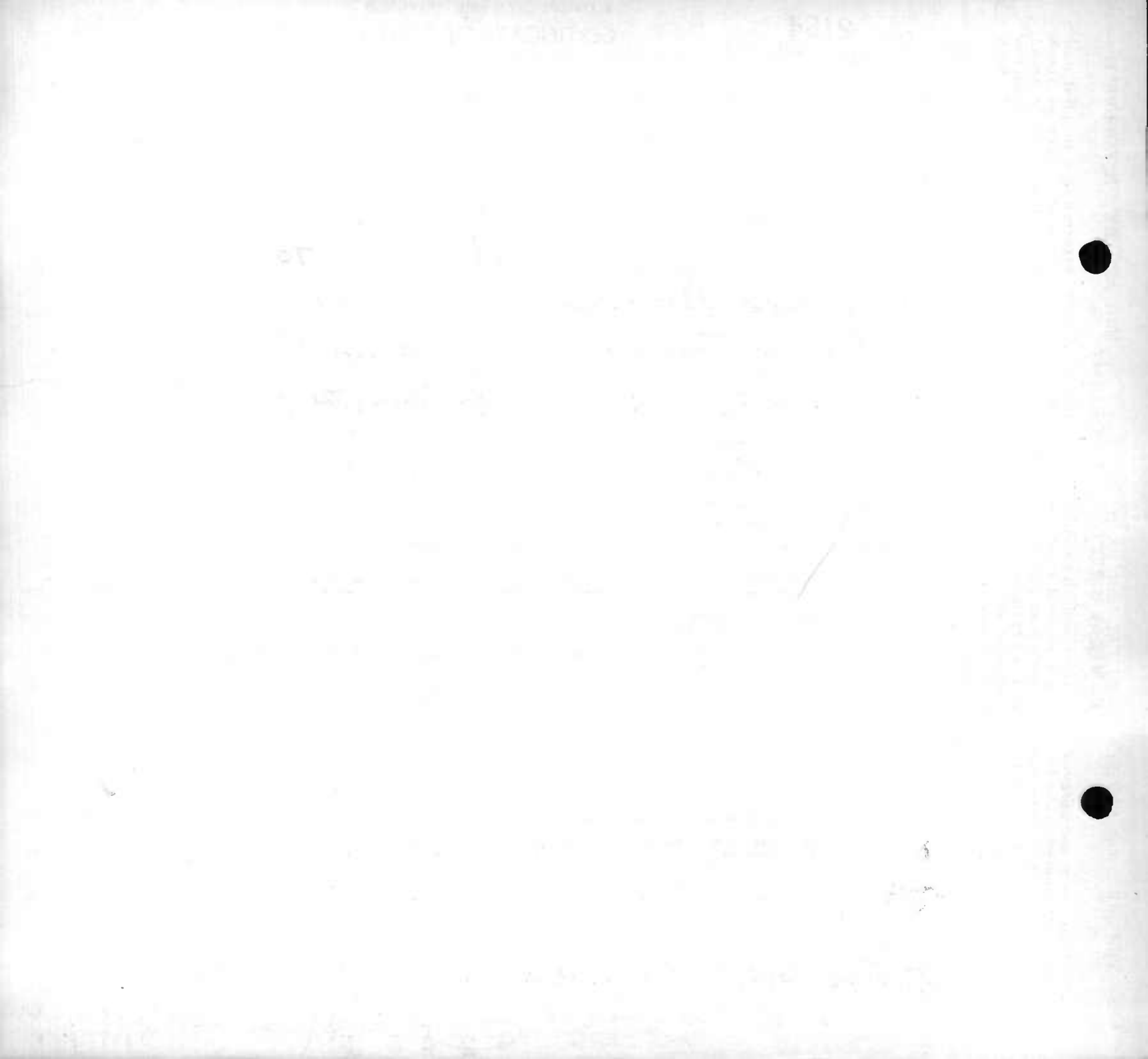
OF THE MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 2164

| | | | | | |
|---|------------------|---|-----------------------------------|--|---|
| BIRTH NO. <u>71 2164</u> | | 1. NAME OF DECEASED (Type or Print) <u>IRVING E. THOMPSON</u> | | 2. DATE AND HOUR OF DEATH <u>3/3/71 - 1240 AM</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>415 N. PORT STREET</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/2/1900</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>PORT AUTHORITY</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>OLIVER THOMPSON</u> | | 14. MOTHER'S MAIDEN NAME <u>ELLA PAUL</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W.I</u> | | 16. SOCIAL SECURITY NO. <u>220-07-2117</u> | | 17. INFORMANT <u>Mrs. Doris E. Thompson - 415 N. Port St.</u> | |
| 18. <u>199.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Probable carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>DOA</u> 19__ to 19__ that (I) (we) last saw the deceased alive on 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Eloise Harman</u> | | 23B. DATE SIGNED <u>3/3/71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>ELOISE HARMAN</u> | | 23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3/5/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>CEDAR HILL CEM.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 5 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Charles J. Miller - 2301 Jefferson St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2165 | |
|---|---|---|---|---|---|
| S535 | | | | BIRTH NO. 71 2165 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) Robert N SINTON | | | 2. DATE AND HOUR OF DEATH February 28, 1971 6:45 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL OF BALTO. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTO. | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER 2021 W Rogers Ave #9 | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/22/90 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Robert D Sinton | | |
| 14. MOTHER'S MAIDEN NAME Daisy Dorr | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 216-01-0891 | | | 17. INFORMANT Alma M. Sinton-2021 W. Rogers Avenue #9 | | |
| 18. CAUSE OF DEATH M. I. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AS CVD (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension (C) Dip Toxicity | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 2/28/71 19 to 2/28/71 19 that (we) last saw the deceased alive on 2/28/71 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death. | | | | | |
| 23A. SIGNATURE Antich | | | 23B. DATE SIGNED 2/28/71 | | |
| 23C. PHYSICIAN'S NAME (Type) ANTICH | | | 23D. ADDRESS Sinai Hosp | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-71 | | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Pikesville, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Anna Cost | |
| 25D. ADDRESS Funeral Chapel-4600 Liberty Hts | | | | | |

100-100000

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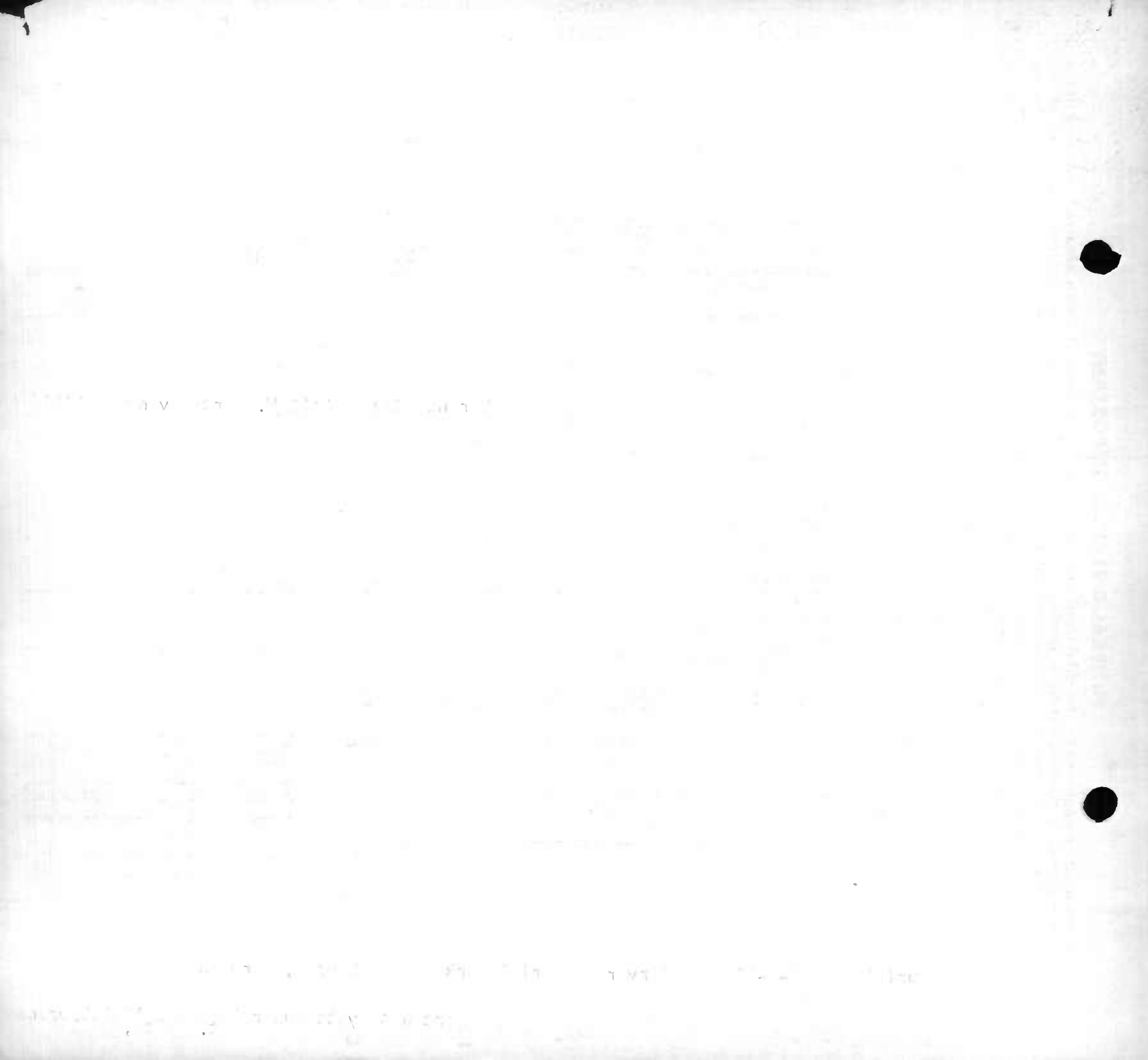
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100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

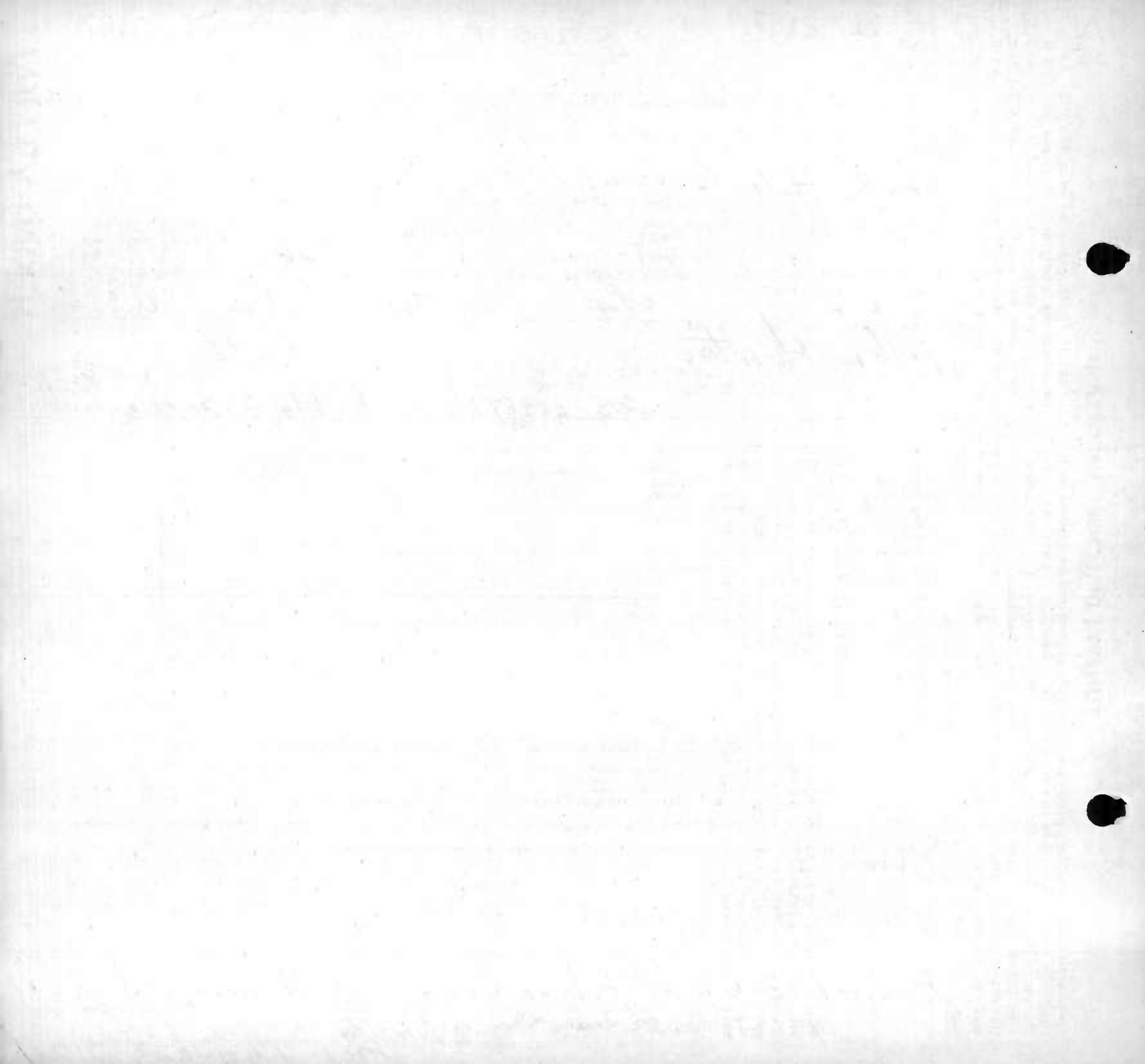
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 2166</u> | |
|---|-------------------------|---|------------------------------------|--|---|---|------------------------------|
| BIRTH NO. <u>2166</u> | | | | 1. NAME OF DECEASED (Type or Print) <u>KEYS, Connie</u> | | 2. DATE AND HOUR OF DEATH <u>3/1/71</u> <u>8:15</u> <u>A</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>33 The Johns Hopkins Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1506</u> | | | |
| | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>2822 W. North Avenue</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/28/24</u> | | 9. AGE (In years last birthday) <u>46</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME <u>Mattie Lewis</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Lorenzo Keys 2822 W. North Avenue 21216</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH <u>(A) Cerebrovascular accident</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive arteriosclerotic</u> (B) <u>Cerebrovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> <u>20 yrs.</u> | |
| | | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that he (this hospital) attended the deceased from <u>Jan 23</u> 19 <u>71</u> to <u>March 1</u> 19 <u>71</u> that (I) we last saw the deceased alive on <u>March 1</u> 19 <u>71</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Douglas L. Hurley, M.D.</u> DEGREE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>3/1/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DOUGLAS L. HURLEY, M.D.</u> DEGREE | | | | 23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-5-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 5 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Morton & Dyett Funeral Home</u> | | ADDRESS <u>1701 Laurens St. Balto, Md 21217</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|---------|--|------------------|--|--|
| 71 2167 | | CERTIFICATE OF DEATH | | 71 2167 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | M. | |
| Bertha NOBLE | | 3 Mar 71 1039 P | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | 1304 | |
| Park Hill Nursing Home | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | | | | |
| 2920 Audubon Dr | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost 1/2) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| F | C | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 Sep 04 | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| n/a | | n/a | | Matthews Co, VA | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U.S.A. | | Allen Hunter | | Amanda Foster | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | 21532-0287 | | James Noble 2920 Audubon Dr | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 2d | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 23. DATE SIGNED | | | |
| that (I) (we) last saw the deceased alive on | | 9 Mar 71 | | | |
| and that in (my) (our) opinion death occurred on the date | | | | | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| J Hulla MD | | 9 Mar 71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| J Hulla MD | | 2214 Fay St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3-6-71 | | Mt. Auburn Co | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| Baltimore Md 21217 | | MAR 5 1971 | | Robert E. Taylor R.D. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| | | | | 2 Martin - Dyett Fitt | |
| | | | | ADDRESS | |
| | | | | 1701 - Laurens 21217 | |



FUNERAL DIRECTOR: IMPORTANT

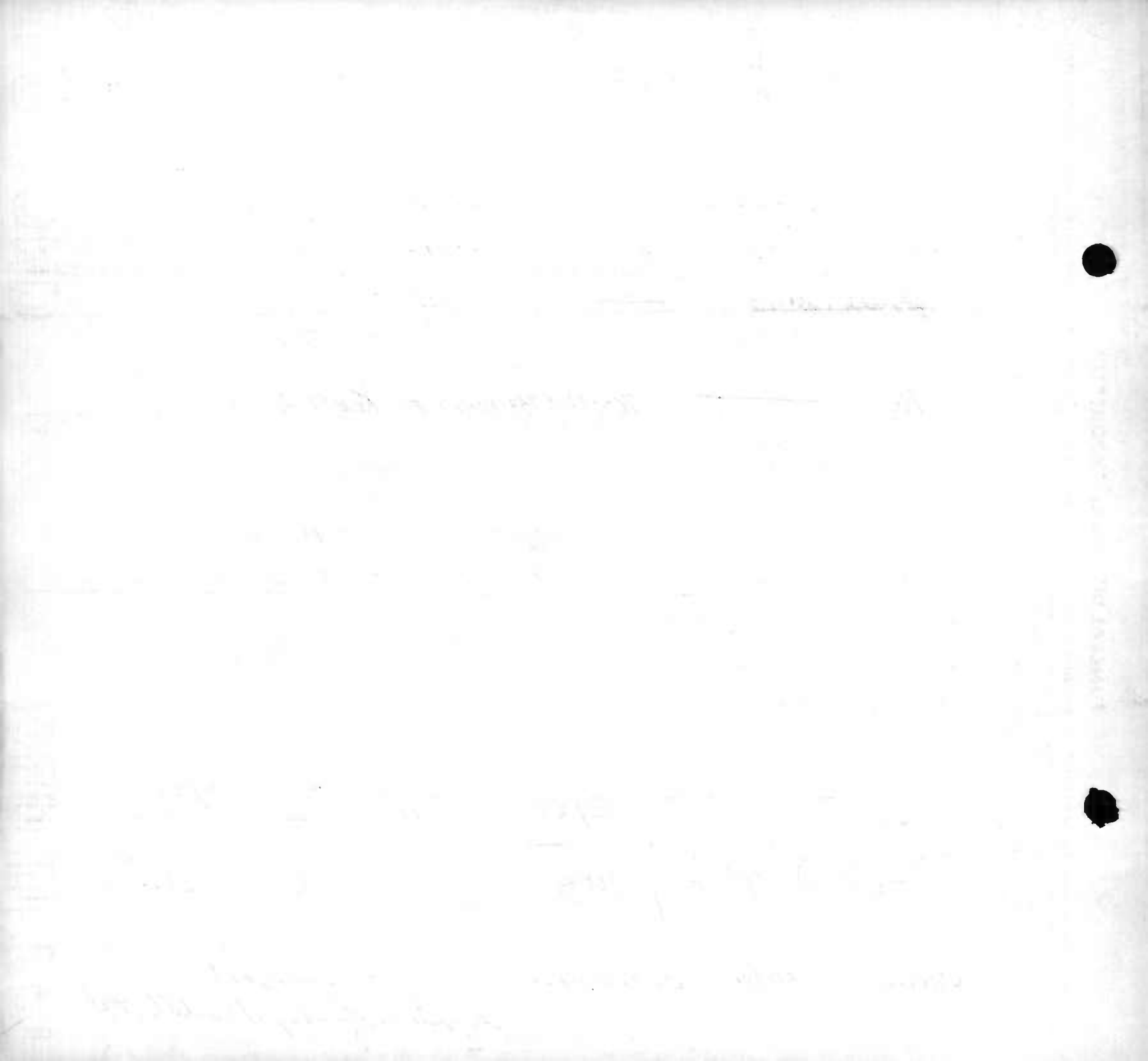
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 2168

| | | | | | |
|--|-------------------------|---|------------------------------------|---|---|
| BIRTH NO. <u>71 2168</u> | | 1. NAME OF DECEASED (Type or Print) <u>Charles Slattery, JR</u> | | 2. DATE AND HOUR OF DEATH <u>2/28/71</u> <u>9:30 P</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2302</u> | | | |
| | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>1520 Hanover St. #212 30</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/21/01</u> | 9. AGE (In years last birthday) <u>69</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXTERNAL NATOR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Charles Slattery</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice Hildebrand</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>705-12-5733</u> | | 17. INFORMANT <u>MARY A. KEEFER - DAUGHTER</u> | |
| 18. <u>710.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE <u>ACUTE HEART FAILURE WITH PLEURAL EFFUSION</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASHIA - Lobar pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>OLD & RECENT MYOCARDIAL INFARCTION</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from <u>2/16</u> 19 <u>71</u> to <u>2/28</u> 19 <u>71</u> . that (U) (we) last saw the deceased alive on <u>2/28</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Patrick A. McDowny M.D.</u> | | 23B. DATE SIGNED <u>2/28/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Patrick A. McDowny M.D.</u> | |
| 23D. ADDRESS <u>SUITLAND, MD</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 24B. DATE <u>3/1/1971</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>CEDAR HILL</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>SUITLAND, MD</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 5 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>W. Brock Dudley, Rouds, Md.</u> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2169

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ivan Melichar F.

2. DATE OF DEATH Known ☒ Estimated ☐ Month 3 Day 1 Year 71 Hour 2:15 a. M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

3. DATE PRONOUNCED DEAD Month 3 Day 1 Year 71 Hour 2:15 a. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY Baltimore

5300

6. SEX

male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Cockeysville

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

July 28, 1918

10. AGE (In years last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

10122 Charington Road

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Arnost Melichar

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer for Black & Decker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Marie Brezobska

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

213-52-3461

18. INFORMANT

ADDRESS

Mrs. Asa V. Melichar Cockeysville, Md.

19.

E9171X

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Multiple injuries

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
SKI LODGE22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
Charnita Ski Lodge22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)
1 17 71 3:00 p.m.22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒22F. HOW DID INJURY OCCUR?
Subject hit a tree while skiing.

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3/1/71

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

March 2, 71

24C. NAME of CEMETERY or CREMATORY

Greenmount Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 5 1971

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

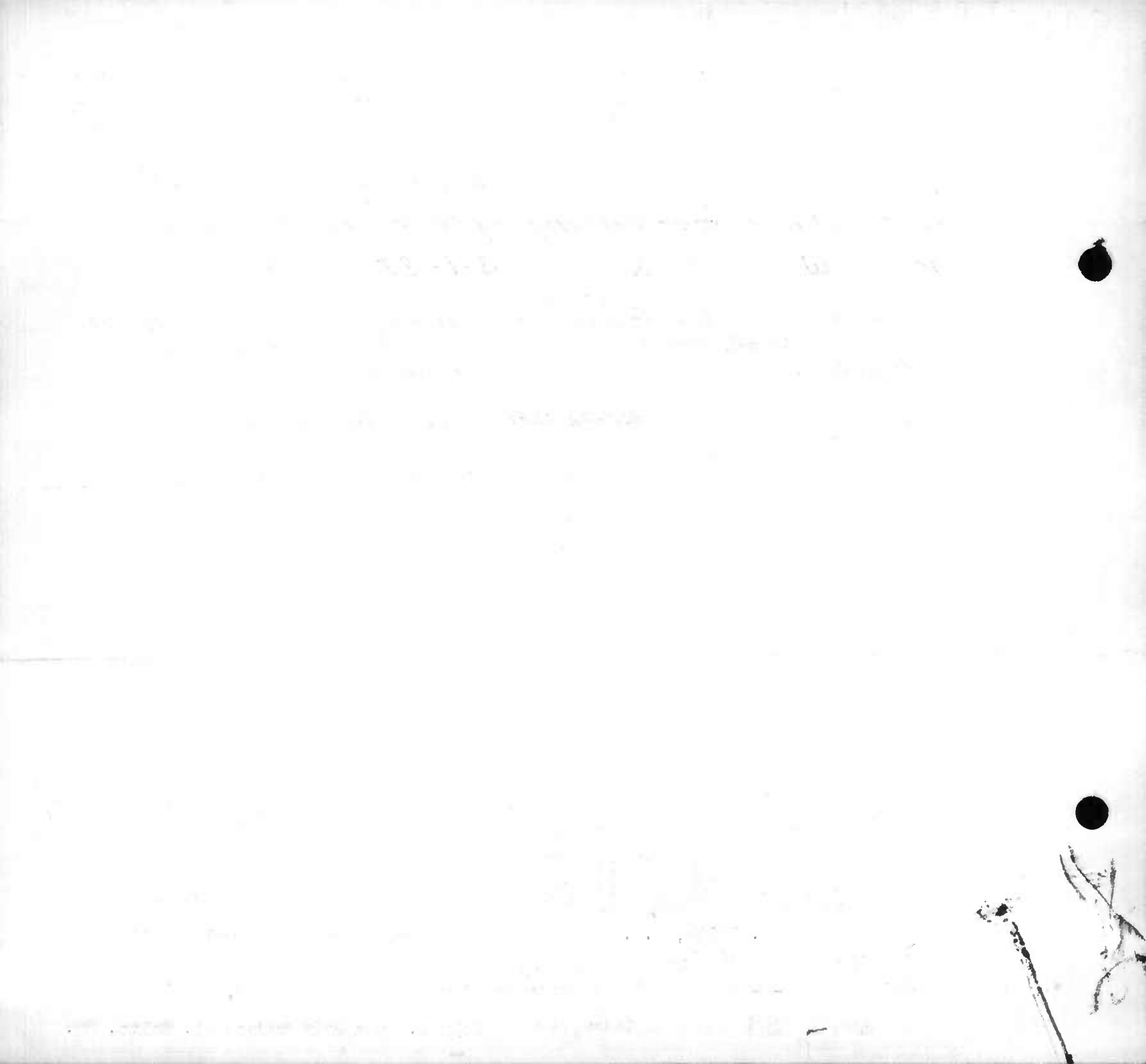
25C. FUNERAL DIRECTOR

ADDRESS

J. F. Eline & Sons Reisterstown, Md.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 2170</u> | |
|---|--|---|--|---|--|---|--|
| BIRTH NO. <u>71 2170</u> | | 1. NAME OF DECEASED (Type or Print) <u>Charles Schaefer</u> | | 2. DATE AND HOUR OF DEATH <u>March 2 1971 7:52 PM.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>49 North Charles General Hosp.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>101</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>49 North Charles General Hosp.</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>m</u> | | 6. RACE <u>w</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-1-88</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> | | 9. AGE (In years last birthday) <u>83</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Michael</u> | | 14. MOTHER'S MAIDEN NAME <u>Purser</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-22-0581</u> | | 17. INFORMANT <u>His Hospital Record</u> | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>731.9 I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Vascular Hemorrhage</u> (B) <u>Arteriosclerosis</u> (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yr</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-27-71</u> to <u>3-2-71</u> that (I) (we) last saw the deceased alive on <u>2-2-71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Leo K. Smith, M.D.</u> | | | | 23B. DATE SIGNED <u>2-2-71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 23E. DEGREE | | | |
| <u>Leo K. Smith, M.D.</u> | | <u>North Charles General Hospital</u> | | <u>MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>3-6-71</u> | | <u>Holy Redeemer Cemetery</u> | | <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 5, 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>John J. Duda</u> | | ADDRESS <u>2829 Hudson St. Balto. Md.</u> | |

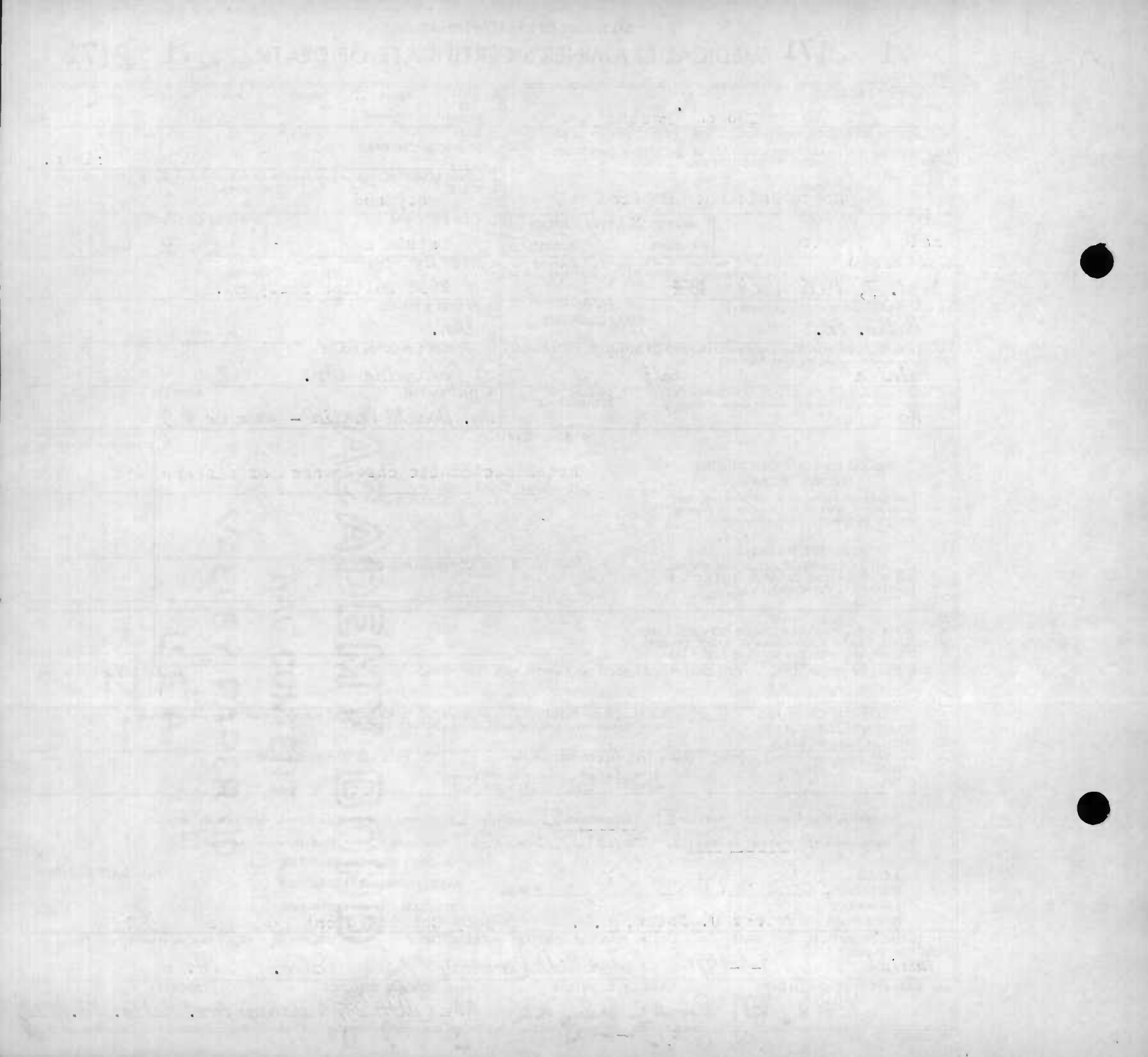


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) Thomas N. Martin | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 2 71 3:10 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2572 | |
| 6. SEX male | 7. RACE white | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH Sept. 7, 1906 | | 10. AGE (In years lost birthday) 64 | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF USA | |
| 13. FATHER'S NAME Ukr. | | 14. STREET AND NUMBER 2851 Hollins Ferry Rd. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 14B. KIND OF BUSINESS OR INDUSTRY Self | |
| 15. MOTHER'S MAIDEN NAME Catherine Ukr. | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Mr. Donald Martin - same as # 5 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) | | DATE SIGNED 3/2/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-5-1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Jaber, M.D. | |
| 25C. FUNERAL DIRECTOR Mc Cully 237 Patapsco Ave. Balto. Md. 21225 | | 25D. ADDRESS | |



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2172 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **2172**

BIRTH NO. **21**

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Sarah Taylor | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 1 Year 71 Hour 10:50 a. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 3. DATE PRONOUNCED DEAD Month 3 Day 1 Year 71 Hour 10:50 a. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 1-24-07 | | 10. AGE (In years, last birthday) 64 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 716-10-9475D | |
| 18. INFORMANT Son: John P. Levinski | | ADDRESS 3122 Elliott St. Balto. Md. | |
| 19. CAUSE OF DEATH Hypertensive cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Peter Lipkovic, M.D. | | DATE SIGNED 3/1/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-5-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Jaber, M.D. | |
| 25C. FUNERAL DIRECTOR John J. Duda | | ADDRESS 2829 Hudson St. Balto., Md. | |

WILLIAM H. HARRIS

WILLIAM H. HARRIS

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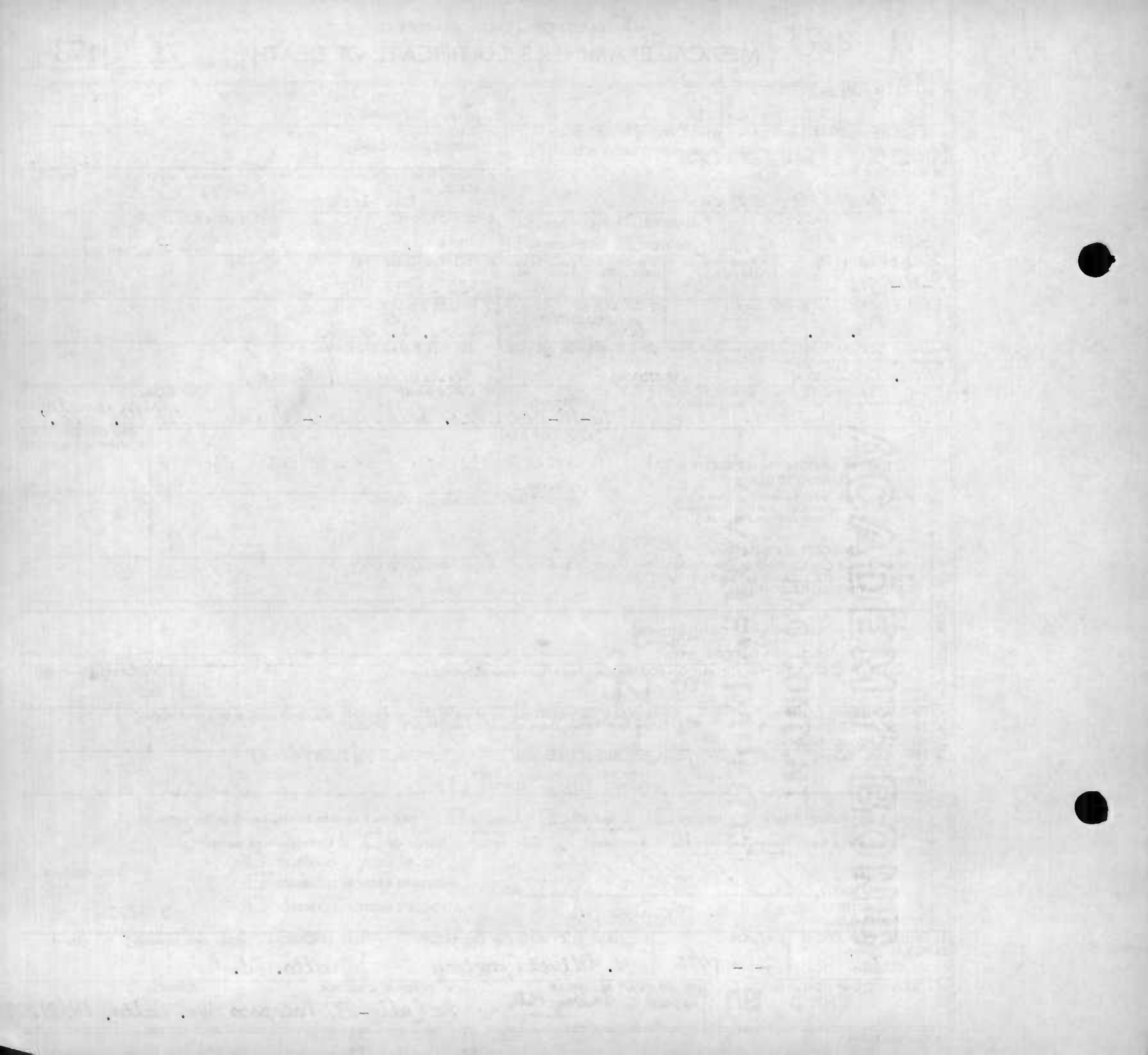
71 2173

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2173

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) EDWARD BROWN | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 955 Jeffrey Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 2, 1971 9:51 P.M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 8-10-1912 | | 10. AGE (in years lost birthday) 58 | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Bartender | | 14B. KIND OF BUSINESS OR INDUSTRY Barroom | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes WW 71 | | 17. SOCIAL SECURITY NO. 212-10-2496 | |
| 15. MOTHER'S MAIDEN NAME Henrietta (Rhode) | | 18. INFORMANT Mrs. Sally Baker-114 Oak Spring Dr. Md. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/3/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-6-1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Mc Cully-237 Patapsco Ave. Balto. Md./21225 | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

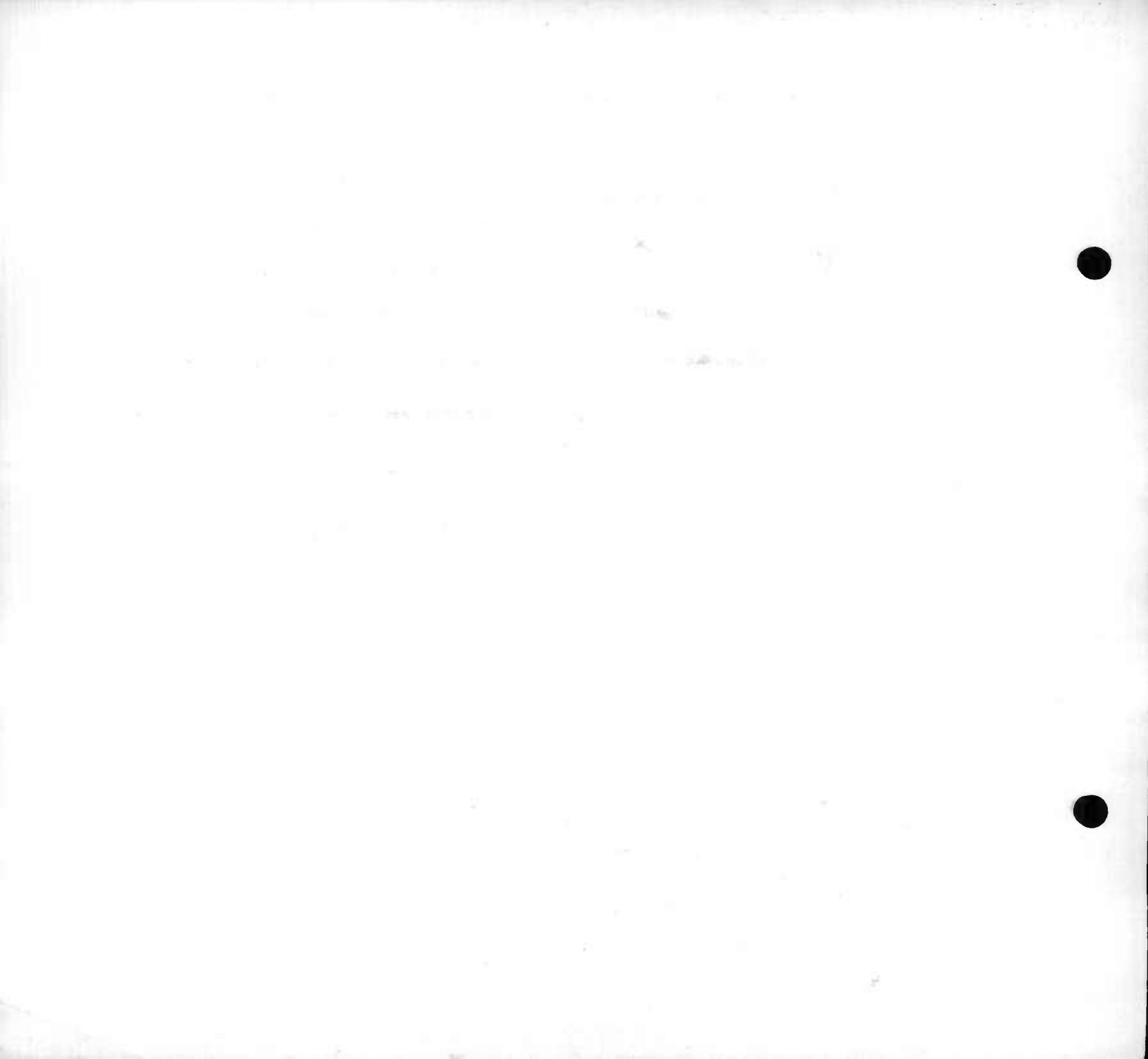
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2174 | | | |
|---|--|--|--|--|--|--|--|
| BIRTH NO. 71 2174 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) GEORGETTE FRAZIER | | | | 2. DATE AND HOUR OF DEATH MARCH 3-1971 9:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1510 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MONTEBELLO STATE HOSPITAL. | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 12-10-08 | | 9. AGE (in years last birthday) 62 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | | | | 10B. KIND OF BUSINESS OR INDUSTRY Delivery of Balto. Virginia | | 11. BIRTHPLACE (State or foreign country) USA | |
| 13. FATHER'S NAME George Green | | | | 14. MOTHER'S MAIDEN NAME Edna ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 220-12-5076 | | | |
| 17. INFORMANT Balease A. Cogdell | | | | ADDRESS 600 W. 150th Street Manhattan, N. Y. | | | |
| 18. 431.01 CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage | | | | 5 days. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension | | | | 3 years. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). LT sided hemiplegia due to CVA | | | | 1-26-71. | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-22-1971 to 3-3-1971 that (I) (we) last saw the deceased alive on 3-3-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 3-3-71 | | | |
| 23C. PHYSICIAN'S NAME (Type) JORGE G. FUXA | | | | 23D. ADDRESS 2201 ARAGONNE DR. BALTIMORE MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 3-6-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2175</u> | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. <u>71 2175</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>WEST, Shirley M.</u> | | | 2. DATE AND HOUR OF DEATH <u>3-3-71</u> <u>4:30 P M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1901</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1407 W. FAYETTE STREET</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>05-30-26</u> | 9. AGE (In years last birthday) <u>44</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>ANDERSON, George R. Sr.</u> | | | 14. MOTHER'S MAIDEN NAME <u>Nightengale, MARGARET</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>?</u> | | |
| 17. INFORMANT <u>Thelma Anderson 2011 Whittier Avenue</u> | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Diabetic Coma - Irreversible Shock</u> | | | CAUSE OF DEATH <u>Diabetic Coma - Irreversible Shock</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes mellitus</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (the) (this hospital) attended the deceased from <u>3-2</u> 19 <u>71</u> to <u>3-3</u> 19 <u>71</u> that (we) last saw the deceased alive on <u>3-3</u> 19 <u>71</u> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>L. de Borja M.D.</u> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>Lilia L. de Borja M.D.</u> | | | | 23D. ADDRESS <u>Bon Secours Hosp 2025 W. Fayette St Baltimore</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-6-1971</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u> | |
| 24D. LOCATION <u>Baltimore</u> | | 24E. STATE <u>Maryland</u> | | 24F. ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 5 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u> | | 25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2176 | |
|---|-------------------------|---|--------------------------------------|---|---|
| BIRTH NO. 71 2176 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mack Lucille</i> | | 2. DATE AND HOUR OF DEATH <i>February 26, 1971</i> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i> | | A. STATE <i>MARYLAND</i> | | B. COUNTY <i>2543</i> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <i>2505 Maisel Street</i> | | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Negro</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5-15-1898</i> | 9. AGE (in years last birthday) <i>73</i> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Pvt. Family</i> | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 13. FATHER'S NAME <i>— ? — Kent</i> | | 14. MOTHER'S MAIDEN NAME <i>? ? ?</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>220-14-4738</i> | | 17. INFORMANT <i>Joseph Mack 2505 Maisel Street</i> | |
| 18. <i>43601</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH <i>Cerebral Vascular Accident</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Hypertension</i> | | | |
| 19. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/12/71</i> 19 to <i>2/26/71</i> 19 that (I) (we) last saw the deceased alive on <i>2/26/71</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Donald N. Hiscop, M.D.</i> | | 23B. DATE SIGNED <i>2/26/71</i> | | 23C. PHYSICIAN'S NAME (Type) <i>DONALD N. HISCOP, M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-2-1971</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i> | |
| 24D. LOCATION <i>Baltimore</i> | | 24E. STATE <i>Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 5 1971</i> | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>NUTTER FUNERAL HOME</i> | | 25D. ADDRESS <i>3035 W. NORTH AVE</i> | |



FUNERAL DIRECTOR: IMPORTANT

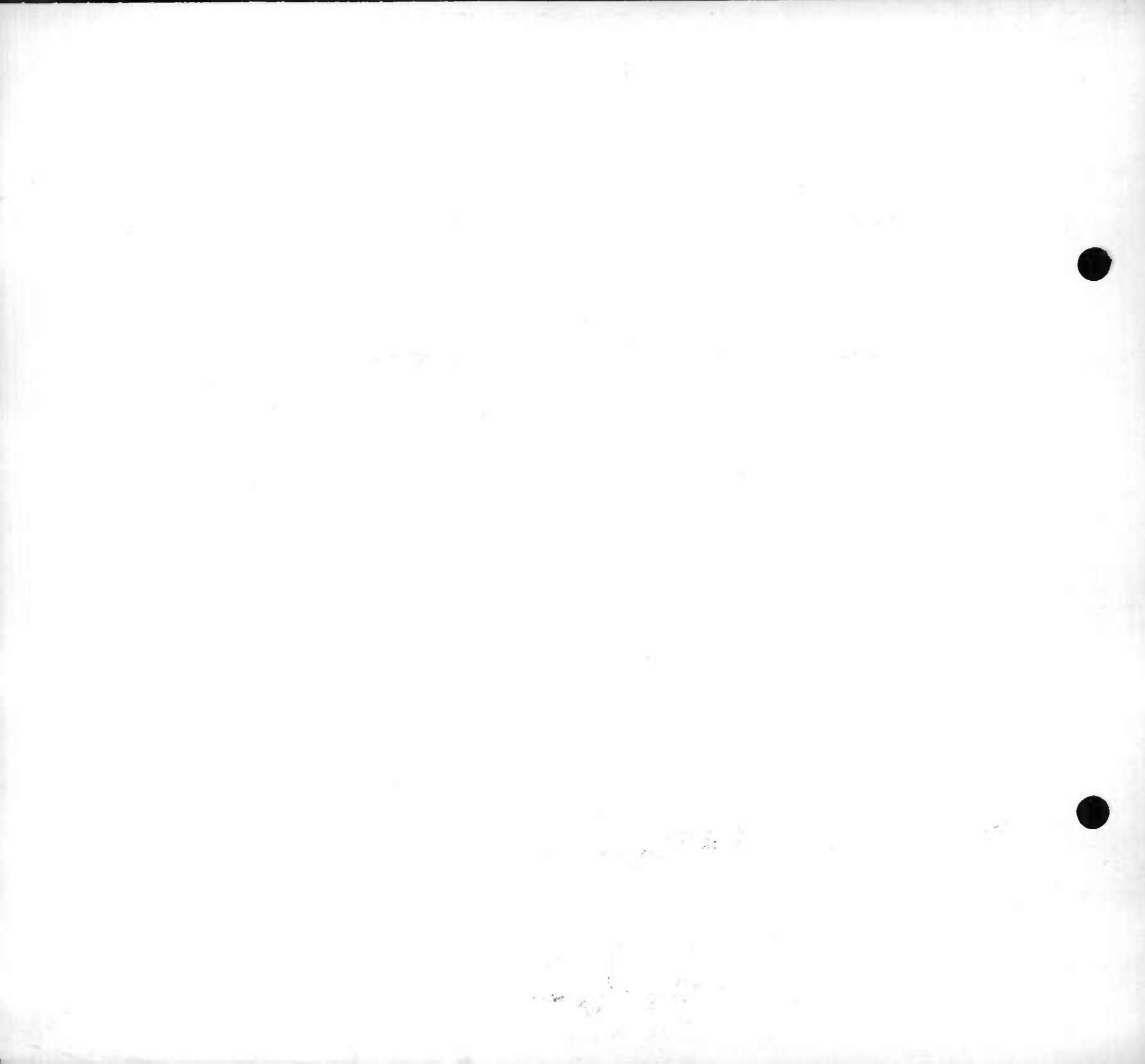
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2177 | |
|--|--|---|---|---|--|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Sister Agnes McLaughlin | | 2. DATE AND HOUR OF DEATH March 1, 1971 9:40 P.M. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 94 Villa Saint Michael | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY City C. CITY OR TOWN Baltimore, D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4000 Forest Hill Road 21207 | | | |
| 5. SEX F. | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 5, 1887 | | 9. AGE (In years last birthday) 83 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Dennis McLaughlin | | 14. MOTHER'S MAIDEN NAME Mary Mannion | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 229-68-4539-J1 | | 17. INFORMANT Sister Andrea ADDRESS Same address | |
| 18. CAUSE OF DEATH | | | | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE Coronary vascular collapse DUE TO, OR AS A CONSEQUENCE OF: (B) Hodgkins disease DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Damian P. Alagia DEGREE | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M.D. DEGREE | | | | 23D. ADDRESS 3326 Frederick Avenue, Baltimore 21228 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/4/71 | | 24C. NAME OF CEMETERY or CREMATORY St. Joseph's Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Emmitsburg, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 5, 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Faber, M.D. | | 25C. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av. (1) ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|-------------------------|---|-------------------------------------|---|---|
| 71 2178 | | CERTIFICATE OF DEATH | | 71 2178 | |
| 1. NAME OF DECEASED (Type or Print) BARNEY BERNARD E | | 2. DATE AND HOUR OF DEATH 2/27/71 7PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 433rd and CALVERT STREETS BALTIMORE, MARYLAND 21218 | | A. STATE BALTIMORE | | B. COUNTY 2201 | |
| | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 727 HANOVER STREET, BALTIMORE, MARYLAND 21201 | | | |
| 5. SEX Male | 6. RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-07-92 | 9. AGE (In years last birthday) 78 years | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICA | | 13. FATHER'S NAME John Barney | | 14. MOTHER'S MAIDEN NAME Laura | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Roland A Brown | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Generalized Carcinomatosis | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Prostate | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Septhaemia | | | | | |
| 19A. DATE OF OPERATION Feb 22, 71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of prostate with metastasis | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 19th 19 71 to Feb 27th 19 71 that (I) (we) last saw the deceased alive on Feb 27th 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Y. K. Shetty | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) DR. Y. K. SHETTY | | 23D. ADDRESS Union Memorial Hospital Baltimore Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-2-71 | | 24C. NAME of CEMETERY or CREMATORY Mt Auburn | |
| 24D. LOCATION (City, town, or county) (State) Balt City | | 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Roland A Brown | | ADDRESS 123rd Mt Montgomery | |



S 534

BALTIMORE CITY HEALTH DEPARTMENT

71 2179

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2179

BIRTH NO.

| | | | |
|---|-------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) VERNA SINDLER | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1101 N. Calvert Street 3-11-71 | | 3. DATE PRONOUNCED DEAD Month Day Year Hour February 27, 1971 2:25 P. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1101 | | | |
| 6. SEX Female | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN Baltimore |
| 9. DATE OF BIRTH Feb 25, 1910 | | 10. AGE (In years last birthday) 61 | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | E. STREET AND NUMBER 1101 N. Calvert Street |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | 13. FATHER'S NAME ? Lane |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. | 15. MOTHER'S MAIDEN NAME Unknown |
| 19. E-9500 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Unidentified drug overdose | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE Barbiturate Overdose DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | |
| 22D. TIME OF INJURY (APPROX.) Several days | | 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1101 N. Calvert Street 1101 | | 22F. HOW DID INJURY OCCUR? Subject ingested drugs | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | DATE SIGNED 2/28/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 3/4/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Greenmount | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Gabe, M.D. | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. | | ADDRESS Baltimore, Md | |

N 96710710002170

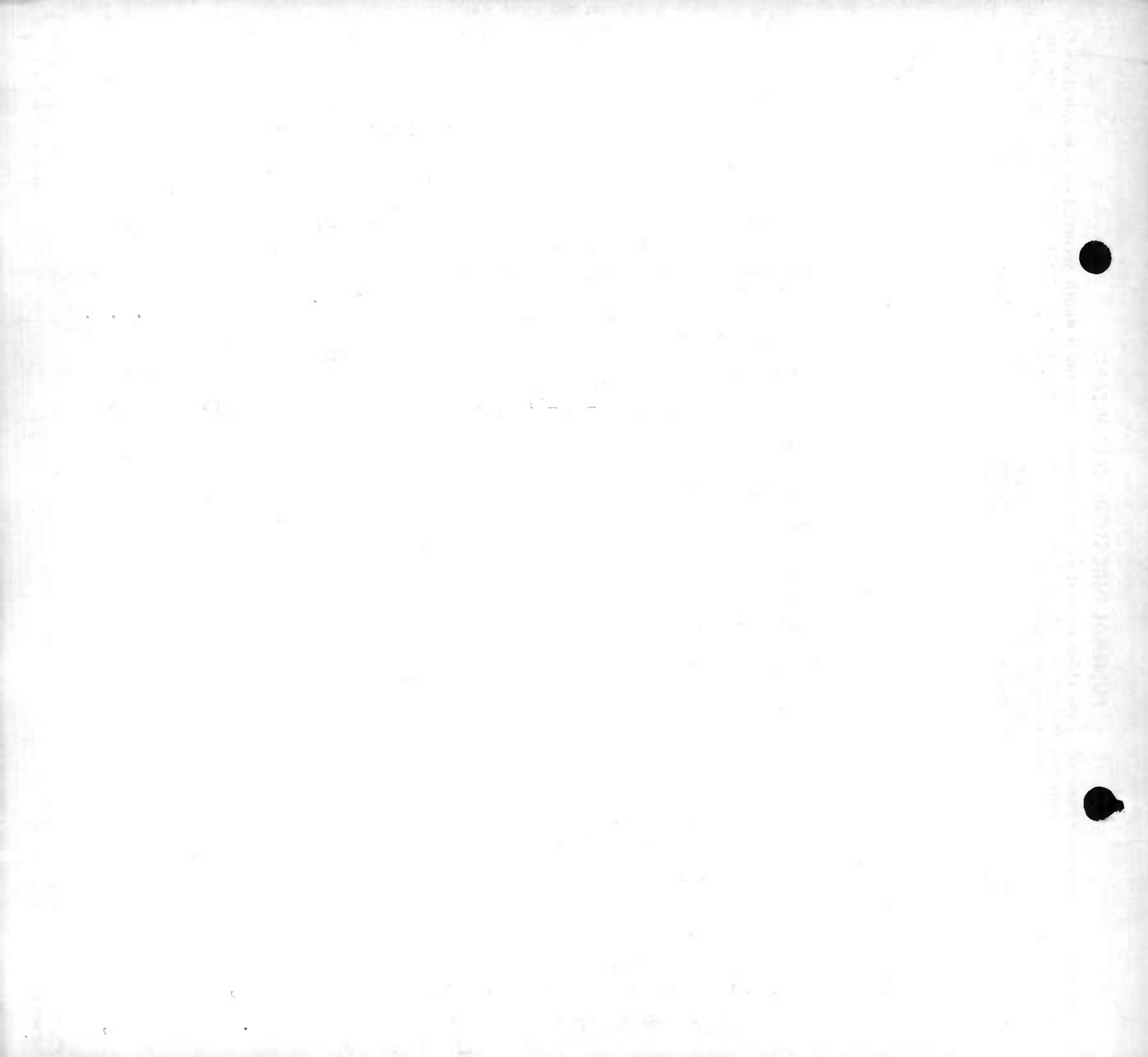
ACADEMY BOND

VALLEY SPRING CO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

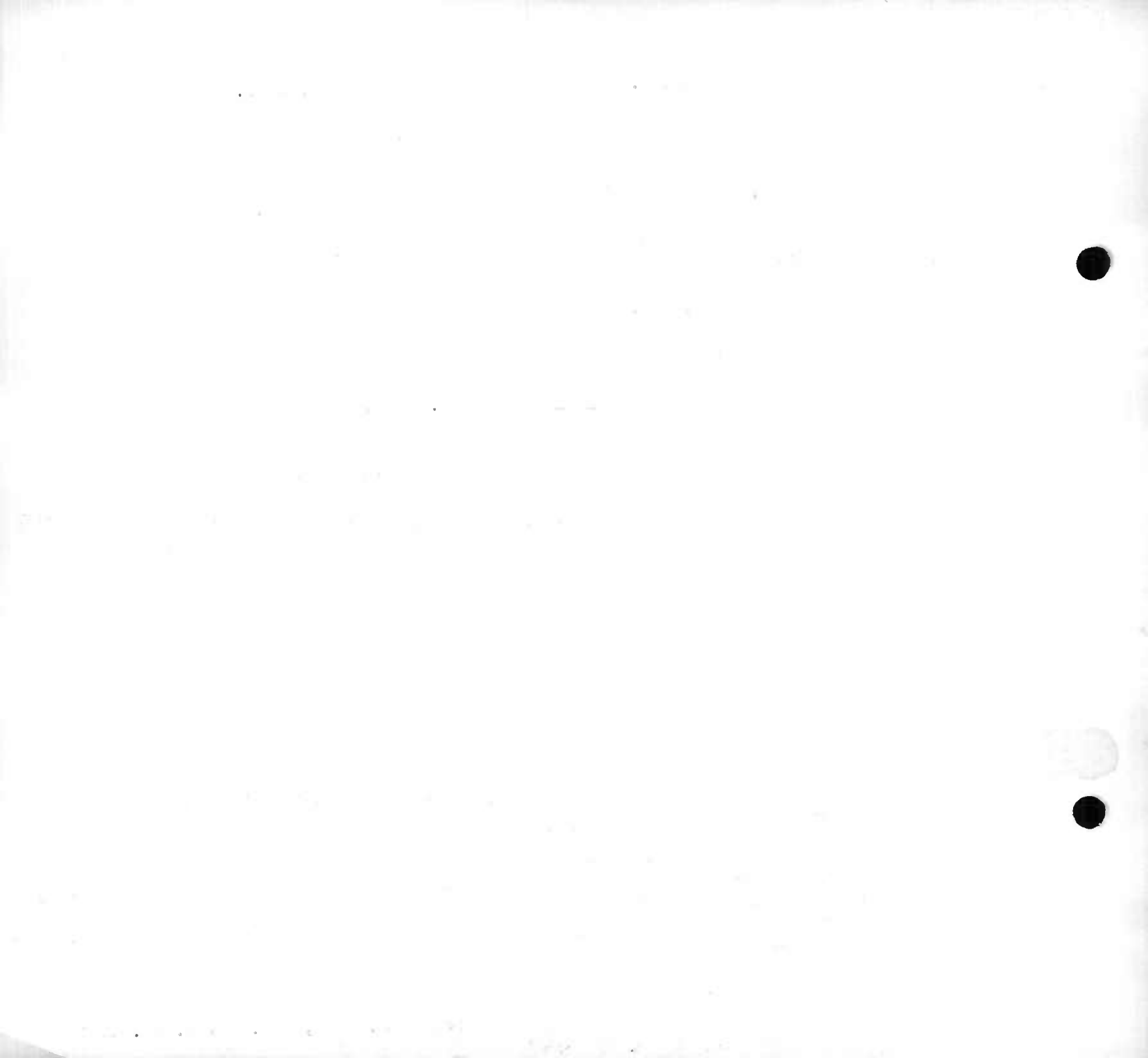
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2180 | |
|--|--|-----------------------------|--|---|--|
| BIRTH NO. 71 2180 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Calvin Phillip Richardson | | | 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 3/2/71 11:20 P.M. </div> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> FULL NAME OF HOSPITAL OR INSTITUTION 37 </div> <div style="width: 50%;"> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital </div> </div> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> A. STATE XXXXXX Maryland </div> <div style="width: 50%;"> B. COUNTY 901 </div> </div> | | |
| 5. SEX <div style="display: flex; justify-content: space-around;"> M W </div> | | | 6. RACE <div style="display: flex; justify-content: space-around;"> W O </div> | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 12/17/14 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 11. BIRTHPLACE (State or foreign country) Pittsville Md. | | |
| 13. FATHER'S NAME Calvin Richardson | | | 14. MOTHER'S MAIDEN NAME Irma Wim brow | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 216-03-3660 | | |
| 17. INFORMANT Mrs Joyce L Trunka | | | ADDRESS 711 Ferguson Rd | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral & Coronary artery of abdomen from Rupture to urinary bladder (B) Coronary artery of Rupture (C) | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/1/71 to 3/2 19 71 | | | 21F. HOW DID INJURY OCCUR? | | |
| 23A. SIGNATURE Thanasophon | | | 23B. DATE SIGNED 3/2/71 | | |
| 23C. PHYSICIAN'S NAME (Type) THANASOPHON | | | 23D. ADDRESS MERCY HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 3/5/71 | | |
| 24C. NAME OF CEMETERY OR CREMATORY London Park Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | |
| 25C. FUNERAL DIRECTOR Leonard J Ruck Inc. | | | ADDRESS Baltimore, Md | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

| | | | |
|--|---------------|---|--|
| BIRTH NO. 71 2181 | | 2. DATE AND HOUR OF DEATH March 3, 1971. 5 55 P.M. | |
| 1. NAME OF DECEASED (Type or Print) WALLACE E. FORSYTH | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1101 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 216 E. Eager Street | | C. CITY OR TOWN Baltimore D. INSIDE CITY (LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 216 E. Eager Street | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 24, 1921 9. AGE (in years last birthday) 49 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Council 11. BIRTHPLACE (State or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Jesse E. Forsyth | | 14. MOTHER'S MAIDEN NAME Cora Cauthorn | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW2 | | 16. SOCIAL SECURITY NO. 259-12-6274 17. INFORMANT Mrs. Flornel Forsyth ADDRESS (Same) | |
| 18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from Oct. 26 1968 to Mar. 3 1971 that (I) (we) last saw the deceased alive on Mar. 3 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE S. J. Liu M.D. DEGREE 23B. DATE SIGNED March 4 1971 23C. PHYSICIAN'S NAME (Type) S. J. Liu M.D. DEGREE 23D. ADDRESS 5301 Harford Road, Balto., Md. 21214 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3/8/71. 24C. NAME OF CEMETERY OR CREMATORY Cairo Cemetery 24D. LOCATION Cairo, Georgia 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 25B. NAME OF REGISTRAR Robert E. Bailey, M.D. 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS | | | |



1
M 320 71 2182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 2182

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Ruth E. Mathews | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1010 St. Paul St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 3 2 71 9:00 a M. | |
| 6. SEX female | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1102 | |
| 9. DATE OF BIRTH April 18, 1904 | | 10. AGE (In years, last birthday) 66 | |
| 11. BIRTHPLACE (State or foreign country) Winchester, Mass. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Bernard Francis Mathews | | 14. MOTHER'S MAIDEN NAME Mary Ann Walsh | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 16. KIND OF BUSINESS OR INDUSTRY Josephite Fathers | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 18. SOCIAL SECURITY NO. 011-03-6337 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/5/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Oak Grove Cem. | | 24D. LOCATION (City, town, or county) (State) Medford, Mass. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | | 25D. ADDRESS | |

Form 100-10

1964 Edition

LAND ACQUISITION
BOND

WARRANT

NO. 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2183</u> | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. <u>71 2183</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>FRANCIS HOWARD I.</u> | | | 2. DATE AND HOUR OF DEATH <u>3-2-71</u> <u>11:30</u> A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>43 SOUTH BALTIMORE GEN. HOSP.</u> | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>2505</u> | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>4611 PENNINGTON AVE</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-8-1881</u> | 9. AGE (in years last birthday) <u>89</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED CONTRACTOR</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>(DEC) Francis</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>(DEC) Unknown</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>22009-8658</u> | | | 17. INFORMANT <u>Mrs Myrtle Hall</u> Same | | |
| 18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <u>3-2-71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) _____ | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-22</u> 19 <u>71</u> to <u>3-2</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3-2</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Jose M. Presbitero M.D.</u> | | | | 23B. DATE SIGNED <u>3-2-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JOSE M. PRESBITERO M.D.</u> | | | | 23D. ADDRESS <u>SBGH BALTO MD.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/5/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 5 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Barber, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Baltimore, Md</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

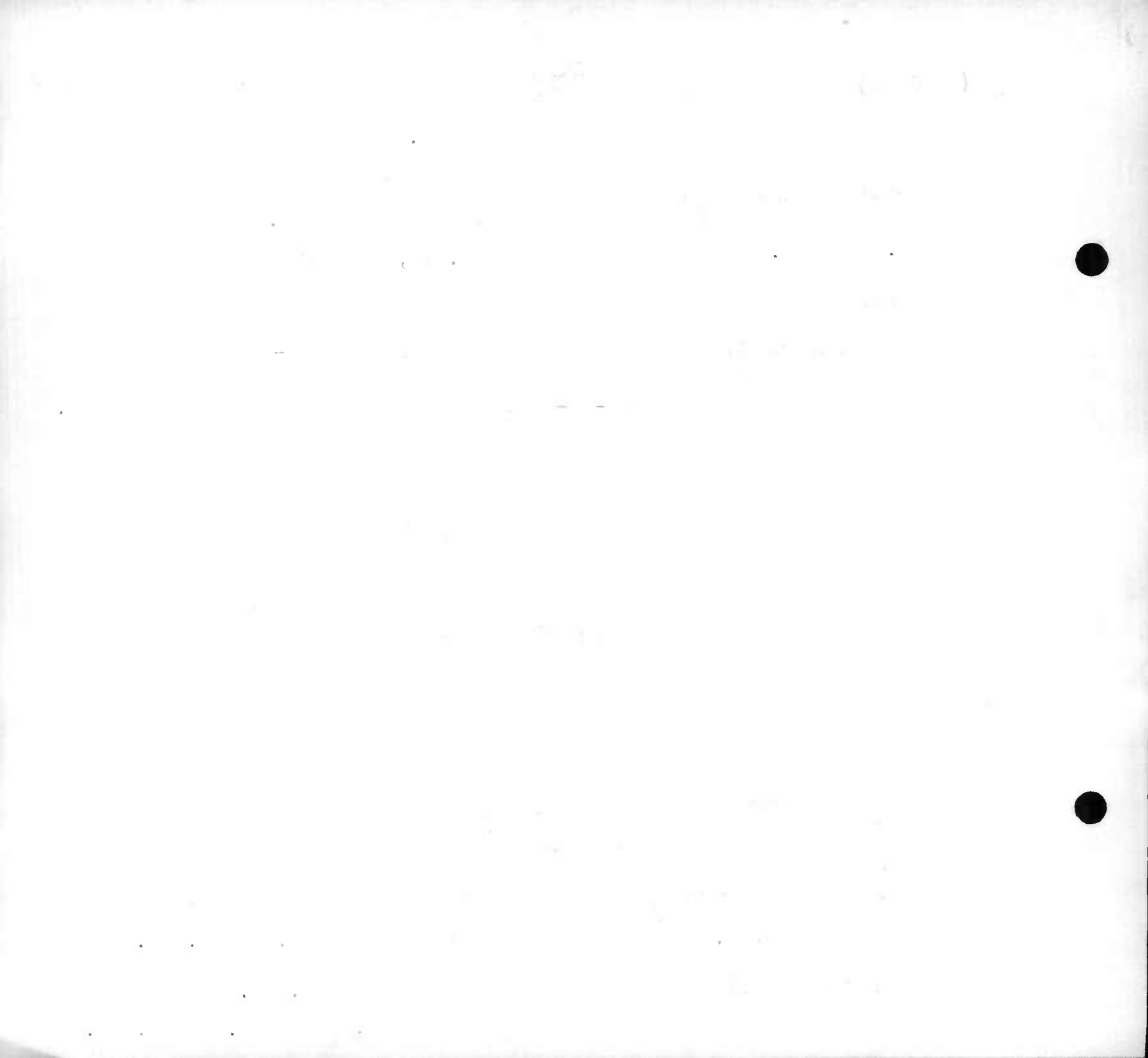
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2184 | |
|---|---|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 71 2184 | | | | | |
| 1. NAME OF DECEASED (Type or Print) MUARRY, GRACE | | | 2. DATE AND HOUR OF DEATH 2-28-71, 9.35 pm | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1307 | | |
| | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER ROLAND AVENUE - 3939 | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-3-1889 | 9. AGE (In years last birthday) 81 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY SECRETARY (RET) | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 13. FATHER'S NAME HOWELL BROWN | | 14. MOTHER'S MAIDEN NAME MARY, UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 046-18-5150 | | 17. INFORMANT Husband | |
| | | ADDRESS Same | | | |
| 18. 450X + 180X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF: (B) BACTERIAL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) PULMONARY EMBOLISM | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CERVIX CANCER | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-28 19 71 to 2-28 19 71 that (I) (we) last saw the deceased alive on 1-28 19 71 and that (n (my) (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Juan H. Cardenas | | 23B. DATE SIGNED 2-28-71 | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3/3/71 | | Baltimore Cem. | |
| 24D. LOCATION (City, town, or county) (State) | | Balto Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 5 1971 | | Jabes E. Taylor, M.D. | | Leonard J. Rock Inc. Balto Md | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 71 2185 | |
|--|--|---|--|---|--|--|--|
| BIRTH NO. 71 2185 | | CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Adelina Di Natale</i> | | 2. DATE AND HOUR OF DEATH <i>3/2/71 1:00 PM</i> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Gould Convalesarium</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX <i>F.</i> 6. RACE <i>W.</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Aug. 17, 1896</i> 9. AGE (in years last birthday) <i>74</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 11. BIRTHPLACE (State or foreign country) <i>Italy</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? <i>Italy</i> | | | |
| 13. FATHER'S NAME <i>John Gargiulo</i> | | 14. MOTHER'S MAIDEN NAME <i>Migell</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>218-03-8776</i> | | 17. INFORMANT ADDRESS <i>Charles DiNatale 1320 Roxboro Rd.</i> | | | |
| 18. <i>4/10/71</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> (B) <i>Arteriosclerotic Cardiovascular Disease</i> (C) <i>Pericarditis; Old Phlebitis; Arthritis; Chronic Benign Syndrome</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>—</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <i>3/2/71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from <i>2/28/1971</i> to <i>3/2/1971</i> that (I) (we) last saw the deceased alive on <i>2/28/1971</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Albert B. Bradley</i> | | 23B. DATE SIGNED <i>3/2/71</i> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Albert B. Bradley MD</i> | | 23D. ADDRESS <i>4900 Belair Rd. Balto. Md.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Entombment</i> | | 24B. DATE <i>3/5/71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Mausoleum</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 5 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Tarkenton, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Truck Inc. Balto. Md.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2186</u> | |
|--|---------------------|---|--|--|--|
| BIRTH NO. <u>71 2186</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>ALEXANDER, LOUISE</u> | | 2. DATE AND HOUR OF DEATH <u>3/2/71</u> <u>3⁴⁵ A M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u> | | A. STATE <u>MD.</u> | | B. COUNTY <u>BALTIMORE</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>3613 COTTAGE AVE, 21215</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5/6/26</u> | 9. AGE (in years last birthday) <u>44</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Richmond Va</u> | |
| 13. FATHER'S NAME <u>William Oyle</u> | | 14. MOTHER'S MAIDEN NAME <u>Bertha Code</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Bertha Green 240210 Small St</u> | |
| 18. <u>614X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>GRAM NEGATIVE SHOCK</u> (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>INTRA-ABDOMINAL ABSCESS</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>SALPINGITIS</u> | | <u>2 weeks</u> | |
| (C) _____ | | | | <u>Weeks</u> | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2/26/71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INTRA-ABDOMINAL ABSCESS</u> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-5-1971</u> to <u>3-2-1971</u> that (I) (we) last saw the deceased alive on <u>3-2-1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Albert M. Menn</u> | | 23B. DATE SIGNED <u>3/2/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>9097</u> | |
| 23D. ADDRESS | | 23E. DEGREE | | 23F. ATTENDING PHYSICIAN Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-5-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Ortulus Cent</u> | |
| 24D. LOCATION <u>Ortulus Rd</u> | | 24E. (City, town, or county) | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 5 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>L. D. Wilson</u> | |
| 25D. ADDRESS | | 25E. (City, town, or county) | | 25F. (State) | |

William D. ...
...
...

For ...
William D. ...
...

... 32-11 ...
...

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2187

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Rev. WILLIAM AYERS</i> | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <i>March 3, 1971</i> | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>1770 E. North Avenue</i> | | 3. DATE PRONOUNCED DEAD Month Day Year Hour <i>March 3, 1971 6:35 P.M.</i> | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH <i>Oct 6, 1891</i> | | 10. AGE (In years lost birthday) <i>79</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Colbert Co. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 14B. KIND OF BUSINESS OR INDUSTRY <i>Preacher</i> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 17. SOCIAL SECURITY NO. <i>215-14-8207</i> | |
| 18. INFORMANT <i>Mrs. Mary S. Ayers</i> | | ADDRESS <i>Same</i> | |
| 19. <i>412.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic cardiovascular disease</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION <i>0</i> | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) <i>Charles S. Springate, M.D.</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>March 4, 1971</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-8-71</i> | |
| 24C. NAME of CEMETERY or CREMATORY <i>MT. Auburn Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 5 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>Ernest O. Wilson</i> | | ADDRESS <i>1000 Brantley Ave</i> | |

ALCANTARA Y BORDA

RECEIVED

EXHIBIT 100-100000

U.S.A.

100

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

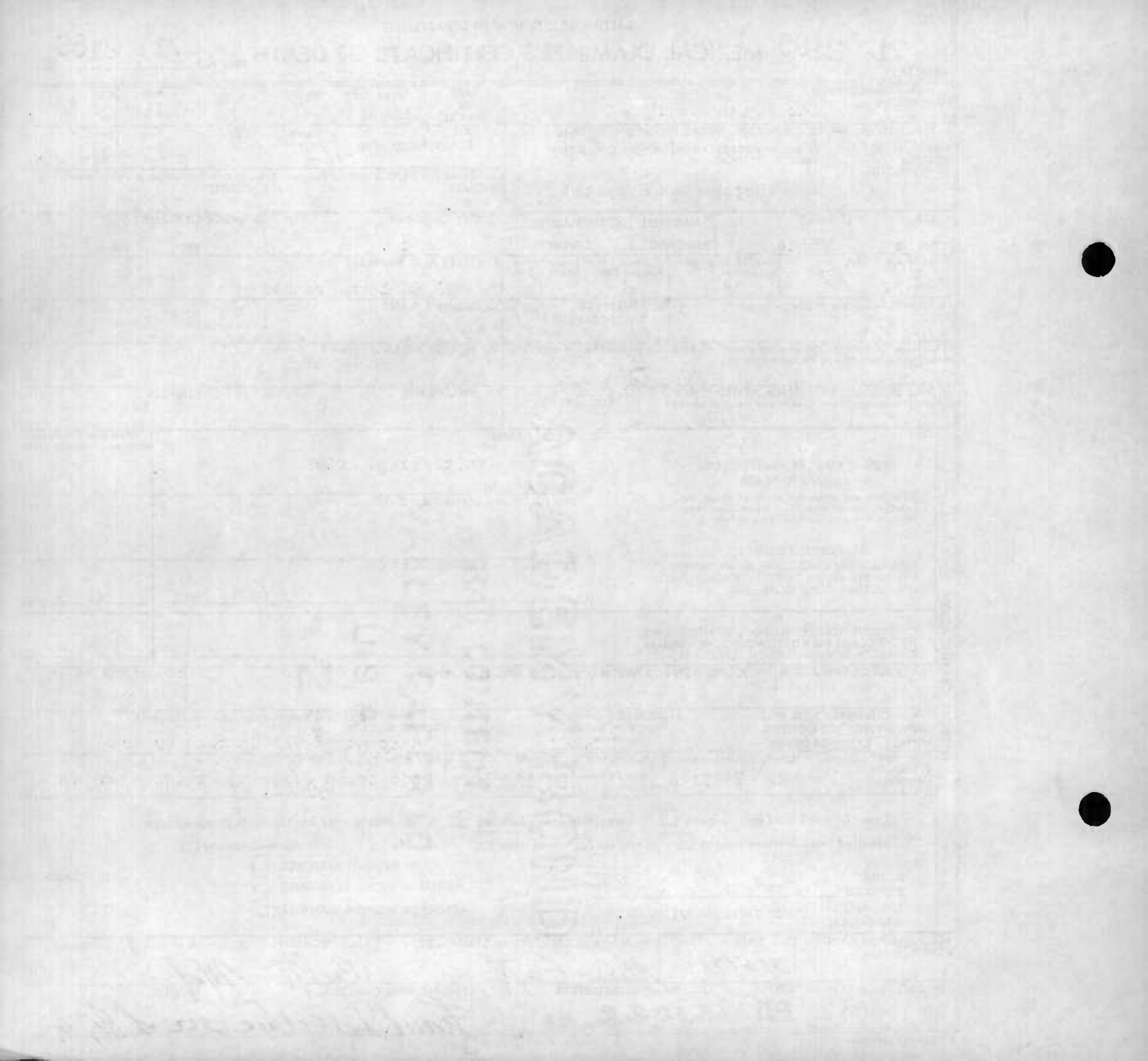
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2188 | |
|---|------------------|--|---|--|---|
| BIRTH NO. 71 2188 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Mrs. Wilhelmina Feldmann | | | 2. DATE AND HOUR OF DEATH 3/2/71 4:45 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 91 Jenkins Memorial 1000 Caton Avenue Baltimore, Maryland 21229 | | | A. STATE Md. City 601 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 18 N. Ellwood Ave | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 9-24-1888 | 9. AGE (in years last birthday) 82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailoress | | | 10B. KIND OF BUSINESS OR INDUSTRY Men's Clothing Tailor Shop Ind. | | 11. BIRTHPLACE (State or foreign country) B Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME August Rothenbuecher | | |
| 14. MOTHER'S MAIDEN NAME Wilhelmina Buettner | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | |
| 16. SOCIAL SECURITY NO. 215-01-8728 | | | 17. INFORMANT Jenkins Memorial 1000 Caton Ave. Balto. Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE 2 MOS. (B) DUE TO, OR AS A CONSEQUENCE OF: A SCVD 6 YRS. (C) CHRONIC AURICULAR FIBRILLATION | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (APPROX.) | | |
| 21E. INJURY OCCURRED | | | 21F. HOW OLD INJURY OCCURRED? | | |
| 22. I certify that (I) (this hospital) attended the deceased from OCT. 19 67 to MARCH 2 19 71 that (I) (we) last saw the deceased alive on MARCH 2, 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John F. Hartman MD | | | 23B. DATE SIGNED March 2, 1971 | | |
| 23C. PHYSICIAN'S NAME (Type) JOHN F. HARTMAN MD | | | 23D. ADDRESS 422 Med. Arts Bldg. Baltimore, Md 21201 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/5/71 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 5, 1971 | | | |
| 25B. NAME OF REGISTRAR V. B. E. Taylor, Jr. | | 25C. FUNERAL DIRECTOR John A. Morgan, Inc. 3000 E. Baltimore St. | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

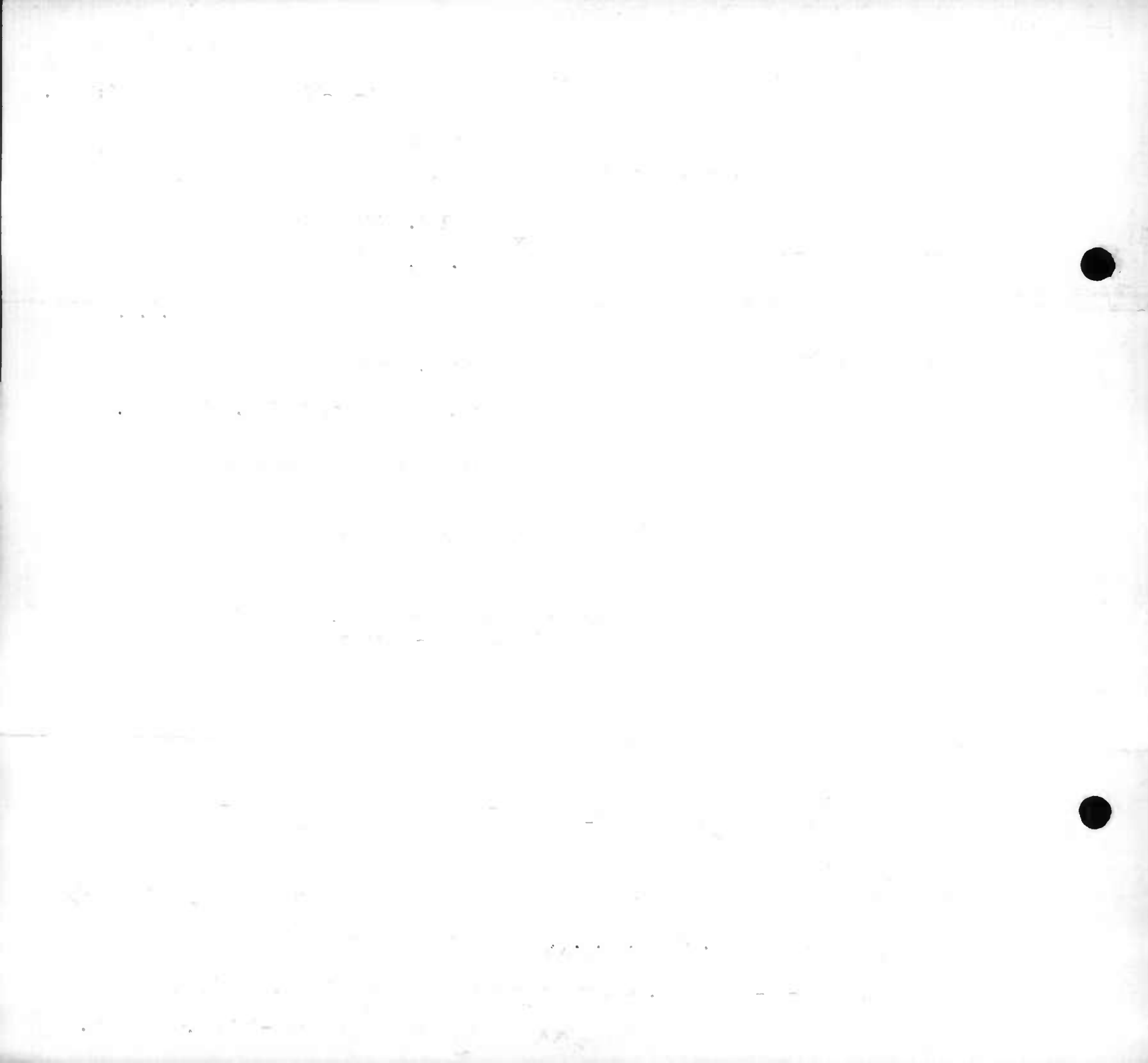
REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Anthony Cossentino | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 1 Year 71 Hour 2:50 a. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home Hospital (If not in hospital or institution, give street address or location) | | 3. DATE PRONOUNCED DEAD Month 3 Day 1 Year 71 Hour 2:50 a. | |
| 6. SEX male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 12/15/85 | | 10. AGE (in years lost birthday) 85 | |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Raffaele Cossentino | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener | |
| 15. MOTHER'S MAIDEN NAME ? | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS | |
| 19. CAUSE OF DEATH E814.7 Multiple injuries | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) In front of 913 Eastern Avenue | | 22D. TIME (Month) (Day) (Year) (Hour) (Minute) (Approx.) 2 28 71 9:15 | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Pedestrian crossing street when hit by car. | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED 3/1/71 | |
| 24A. BURIAL-CREATION, REMOVAL (Specify) | | 24B. DATE 3/5/71 | |
| 24C. NAME OF CEMETERY or CREMATORY New Cath | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR Frank Delaplane 322 S High | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2190</u> | |
|--|---------|---|---|--|---|
| 71 2190 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Linda Horne | | 2-15-71 3:20 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 DOA University Hospital | | | Maryland 1506 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 1701 N. Hilton Street | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Female | Negro | | Oct. 24, 1954 | 16 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | None | | Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| John McFadden | | | Eva M. Horne | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | None | | Mrs. Eva Waters, 1701 N. Hilton St. | |
| 18. CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Asphyxia Due to Aspiration | | |
| | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (B) Ruptured Pulmonary Abscess DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | Severe Mental Retardation, Anaurotic Familial Idiocy - Suspect | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 4-2 19 68 to 2-15 19 71 that (we) last saw the deceased alive on 2-15 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Richard A. Jones, M.D. | | | | 2 Mar 71 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Richard A. Jones, M.D. | | | | Rosewood State Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2-20-71 | | Mt. Auburn Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 5 1971 | | Robert E. Taylor, R.D. | | Nutter Funeral Home-3035 W. North Ave. | |



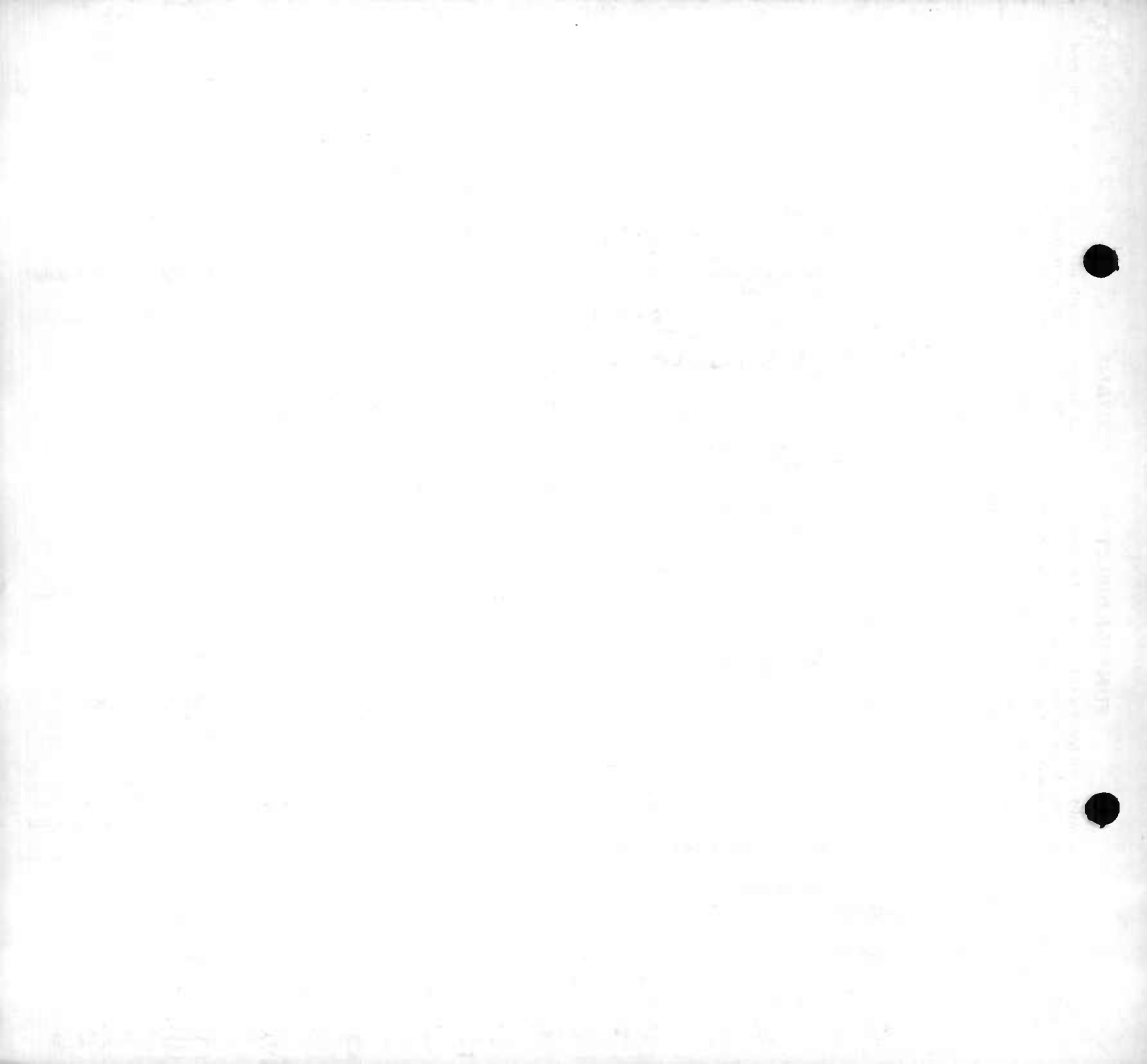
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 2191

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. <u>71-2191</u> | | 1. NAME OF DECEASED (Type or Print) <u>Christian George</u> | | 2. DATE AND HOUR OF DEATH <u>1/16/71 10:20 AM</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Balto Gen Hosp</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>South HANOVER ST 2301</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>M</u> | | 6. RACE <u>N</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>9-16-20</u> | | 9. AGE (in years last birthday) <u>50</u> | | 10. UNDER 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>US</u> | | 13. FATHER'S NAME <u>James Christian</u> | | 14. MOTHER'S MAIDEN NAME <u>Frances Christian</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>212-304286</u> | | 17. INFORMANT <u>Family 914 S Hammon St</u> ADDRESS | |
| 18. <u>450X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Pul. embolism</u> (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Sumat Dine, M.D.</u> | | 23B. DATE SIGNED <u>1/16/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Sumat Dine, M.D.</u> | |
| 23D. ADDRESS | | 23E. FINANCIAL DIRECTOR | | 23F. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. NAME of REGISTRAR | | 24F. FINANCIAL DIRECTOR | |
| 24G. DATE REC'D BY HEALTH DEPT. | | 24H. NAME of REGISTRAR | | 24I. FINANCIAL DIRECTOR | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Lomer Pritchett

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 2192

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

2. DATE AND HOUR OF DEATH

2-15-1971

8.10 P. M.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1726 Brady Avenue

21226

5. SEX

F

6. RACE

Negro

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

1-31-01

9. AGE in years

70

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Willie Miller

14. MOTHER'S MAIDEN NAME

Heath, Delia

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

BCH RECORDS:

ADDRESS

4940 Eastern Avenue
Baltimore, Md. 21224

18. 456.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Uremia

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

G.I. bleeding

(C)

E. Sphygmomanometer

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 3/1/1970 to 2/15/1970 that (X) (we) last saw the deceased alive on 2/15/1971 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H.S. Goldberg, M.D.

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

2/15/71

23C. PHYSICIAN'S NAME (Type)

H.S. Goldberg, M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

24A. BURIAL CREMATION REMOVAL (Specify)

24B. DATE

Burial 2/22/71

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cemetery

24D. LOCATION

A.A.C. Ind

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 5 1971

25B. NAME OF REGISTRAR

R. E. E. Taylor, Jr.

25C. FUNERAL DIRECTOR

Robert Williams

ADDRESS

1701 N. Bond St.

[Faint handwritten text at the bottom of the page, likely bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 2193

BIRTH NO. 71 2193

1. NAME OF DECEASED (Type or Print) SEIDMAN, JACOB

2. DATE AND HOUR OF DEATH

3/2/71 5:30 pm

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

140 N. Curley St.

5. SEX

M

6. RACE

C

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

4/1/99

9. AGE (In years lost birthday)

71

If Under 1 Yr. Months

If Under 24 Hrs. Days

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

underpasser

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

293 16 5563

17. INFORMANT

Noop clerk

ADDRESS

18. 427.21

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac arrest, progressive cardiac decompensation

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 hours

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Renal Failure, uremia

19A. DATE OF OPERATION

2-22

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Perforated duodenal ulcer

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-22 1971 to 3-2 1971

that (I) (we) last saw the deceased alive on 3-2 1971 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Randolph E. George, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

3-2-71

23C. PHYSICIAN'S NAME (Type)

DR. RANDOLPH GEORGE M.D.

23D. ADDRESS

Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/3/71

24C. NAME OF CEMETERY or CREMATORY

Fairland L20

24D. LOCATION

Balto

(City, town, or county)

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

MAR 5 1971

25B. NAME OF REGISTRAR

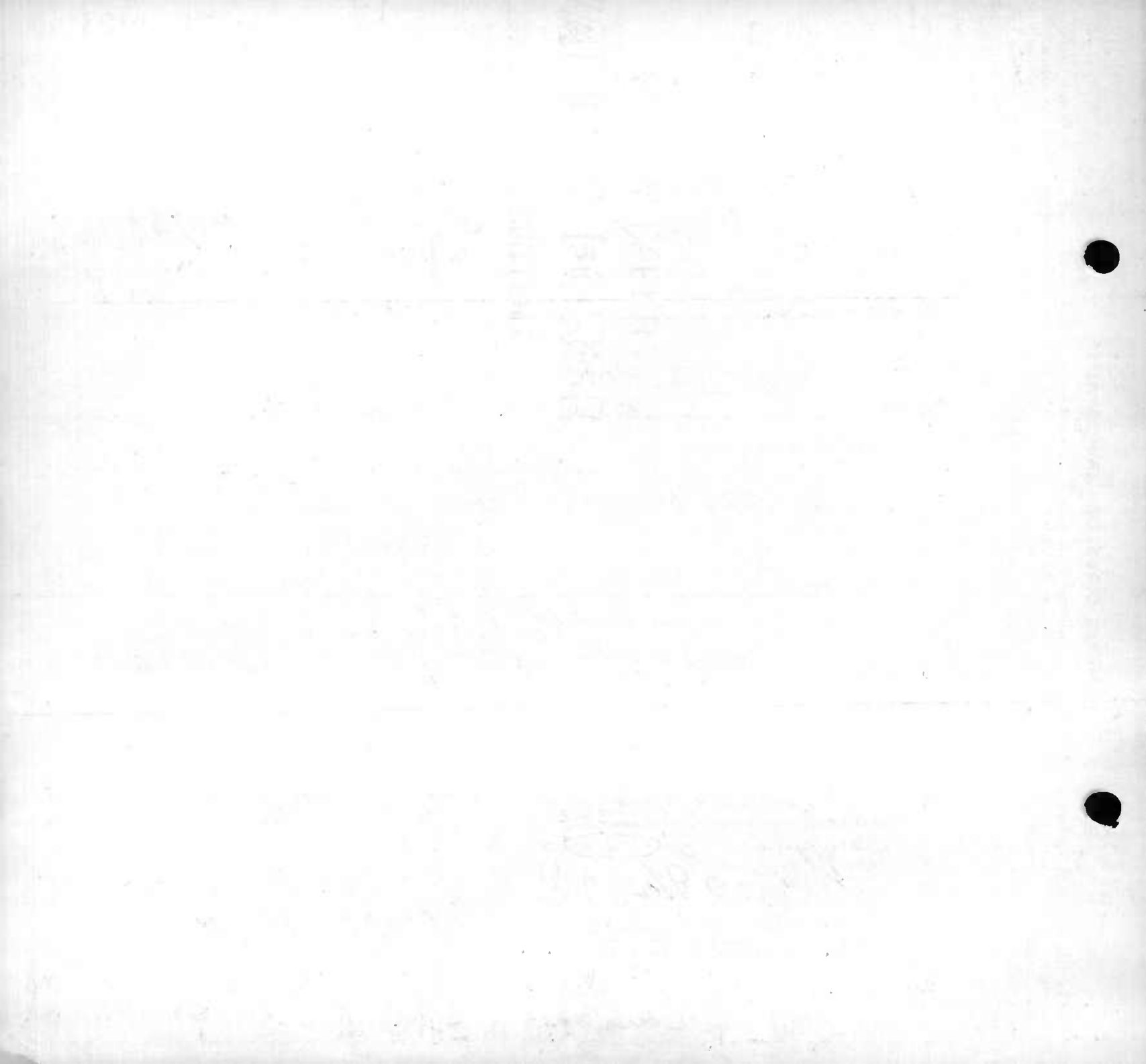
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Sylvia Quinlan

ADDRESS

Garrison Md



1
S 536

71 2194

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2194

| | | | | | | |
|--|--|---|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JOHNNY SANDERS | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year | | Hour |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL | | 3. DATE PRONOUNCED DEAD February 20, 1971 | | Month Day Year | | Hour M. 3:00 P. |
| 6. SEX Male | | 7. RACE Negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Harford 6200 |
| 9. DATE OF BIRTH Feb 28, 1938 | | 10. AGE (in years lost birthday) 35 | | 11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min. | | C. CITY OR TOWN Perryman D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country) Birmingham, Alabama | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Unknown | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not known | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Lillie Bul Sanders | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT Robinson J. Home, Baltimore, Ala. | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E965 X DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH Shotgun wounds of chest and abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Mitchell Lane | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Perryman, Maryland 6200 | | |
| 22D. TIME OF INJURY (APPROX.) 2-20-71 11:25 A.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Shot during altercation | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/21/71 | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-28-71 | | 24C. NAME OF CEMETERY or CREMATORY Local Cem. Atmore, Ala. | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Atmore, Ala. |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR Joseph L. Meser 222 N. Montrose, Baltimore, Md. | | |

STATE OF NEW YORK
IN SENATE
January 10, 1907.

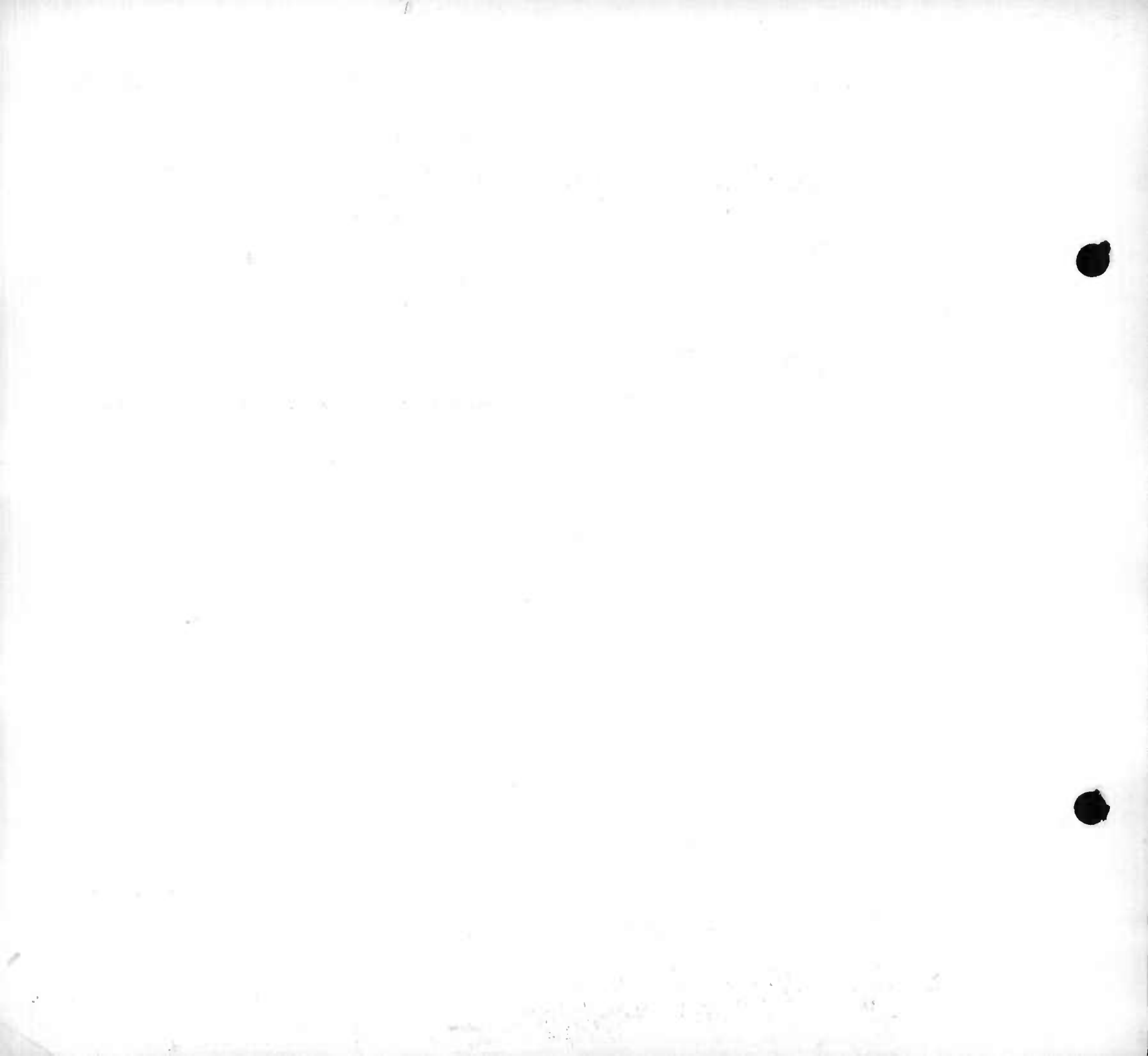
REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 10, 1907.

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS.
1907.

FUNERAL DIRECTOR: IMPORTANT

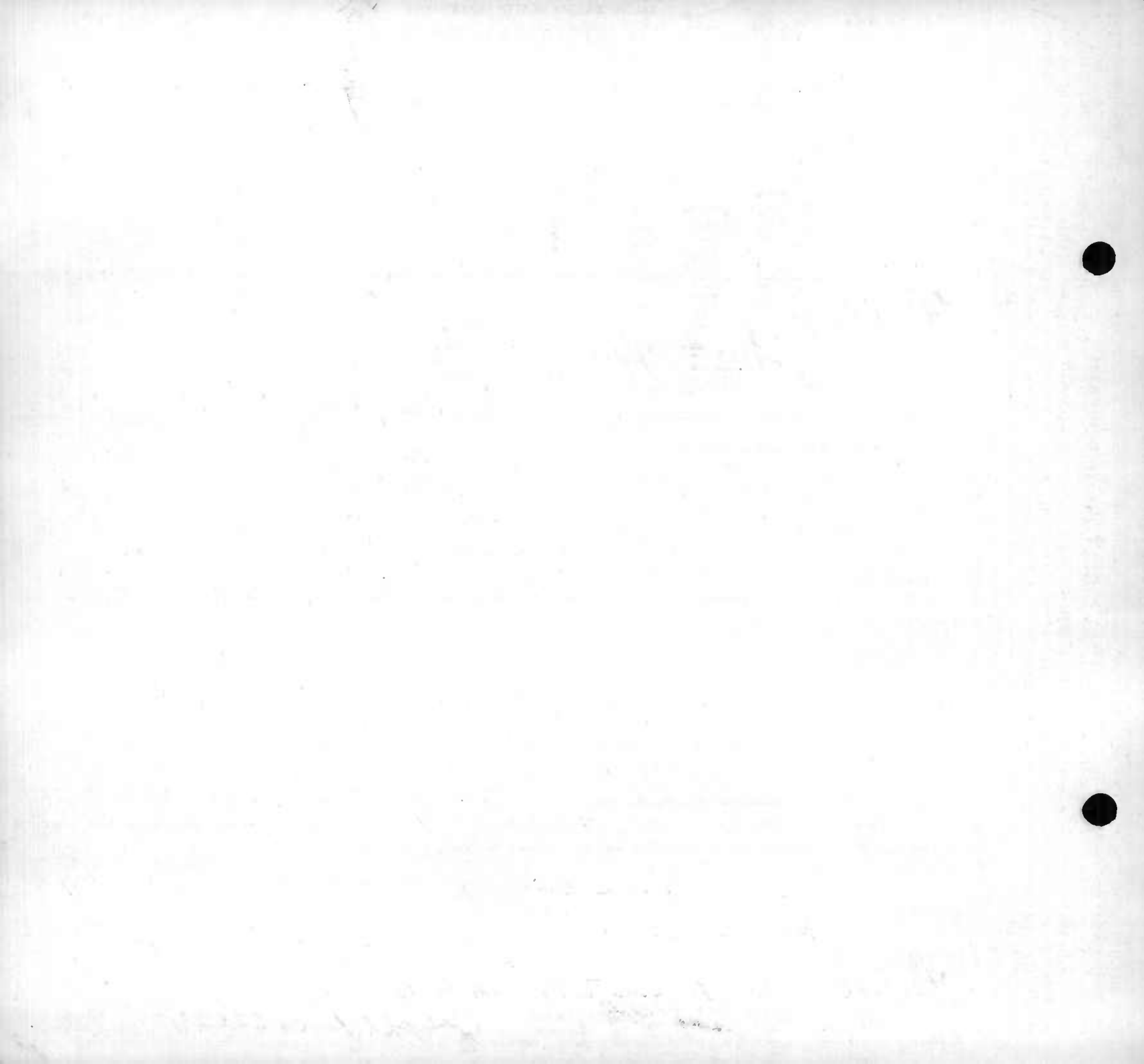
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2195 | |
|---|-------------------------|---|---|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 71 2195 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Gaskins, Leander | | | 2. DATE AND HOUR OF DEATH 2/24/71 11:40 P. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 | | | A. STATE Maryland | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215 | | | B. COUNTY 1602 | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 1402 W. Franklin Street | | |
| 5. SEX Male | 6. RACE Black | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/13/08 | 9. AGE (In years last birthday) 62 | 10. Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Cook | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) Va.. | | | 12. CITIZEN OF WHAT COUNTRY? U.. S. A. | | |
| 13. FATHER'S NAME James H. Gaskins | | | 14. MOTHER'S MAIDEN NAME Lorey Robinson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 219-18-7609 | | 17. INFORMANT Mrs. Elizabeth Gaskins-Wife |
| | | | ADDRESS Same | | |
| 18. 396.91 CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Biventricular Heart failure</p> <p>(B) Aortic Mitral insufficiency DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) With Atrial fibrillation & Ventricular bigeminy</p> </div> <div style="width: 50%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/23/71 to 2/24/71 19 to 19 that (I) (we) last saw the deceased alive on 2/24/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Y. K. RAMAIAH, M.D. | | | | 23B. DATE SIGNED FEB. 25, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) Y. K. RAMAIAH, M.D. | | | | 23D. ADDRESS 2600 Liberty Heights Ave. Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | |
| 24D. LOCATION Westport (Baltimore) Md. | | 25A. DATE REC'D BY HEALTH/DEPT. MAR 5 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Gaskins | | 25C. FUNERAL DIRECTOR Joseph L. Gaskins 2222 W. North Ave | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2196 | |
|--|--|--|--|---|--|
| 71 2196 | | | | BIRTH NO. | |
| 1. NAME OF DECEASED (Type or Print) Fennell Mary | | 2. DATE AND HOUR OF DEATH 2/24/71 | | 5 ³⁰ A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Sinai Nursing Home 4613 Parkheight Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY 1607 | | | |
| 5. SEX F | | 6. RACE B/K | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 1/29/84 | | 9. AGE (In years last birthday) 87 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Scott Holley | | 14. MOTHER'S MAIDEN NAME Cornelia Holley | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Mary Holley 2812 Prestman St | |
| 18. 412.31 | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis Arteriosclerotic Heart Disease | | 3 weeks 1 year | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: none | | (C) none | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 17 19 71 to Feb 24 19 71 , that (I) (we) last saw the deceased alive on Feb 24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Manuel Levin MD | | 23B. DATE SIGNED 2/25/71 | | 23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN | |
| 23D. ADDRESS 6101 PARK HEIGHTS AVE BALTO MD | | 23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 23F. ATTENDING PHYS. <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Feb 27, 71 | | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION (City, town, or county) Arbutus | | 24E. STATE md. | | 24F. FUNERAL DIRECTOR Joseph E. Lewis 2223 W. North Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor MD | | 25C. ADDRESS 2223 W. North Ave | |



F250

BALTIMORE CITY HEALTH DEPARTMENT

71 2197

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2197

BIRTH NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) LILLIE FAISON | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Date Month Day Year Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1705 N. Rosedale Street | | 3. DATE PRONOUNCED DEAD February 28, 1971 | | 1:50 A. M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1506 | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX Female | | 7. RACE Negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH Jan. 1, 1900 | | 10. AGE (In years last birthday) 70 | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | ADDRESS | | 19. CAUSE OF DEATH Arteriosclerotic and hypertensive (A) IMMEDIATE CAUSE cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ | |
| 20. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) NO | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 2/28/71 DATE SIGNED | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-71 | | 24C. NAME OF CEMETERY OR CREMATORY Carver Mem. Park | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR Joseph L. Lusa | |
| 25D. ADDRESS 2222 W. North Ave. | | 25E. ADDRESS | | 25F. ADDRESS | |

ALBANY, N.Y. 12208

ALBANY, N.Y. 12208

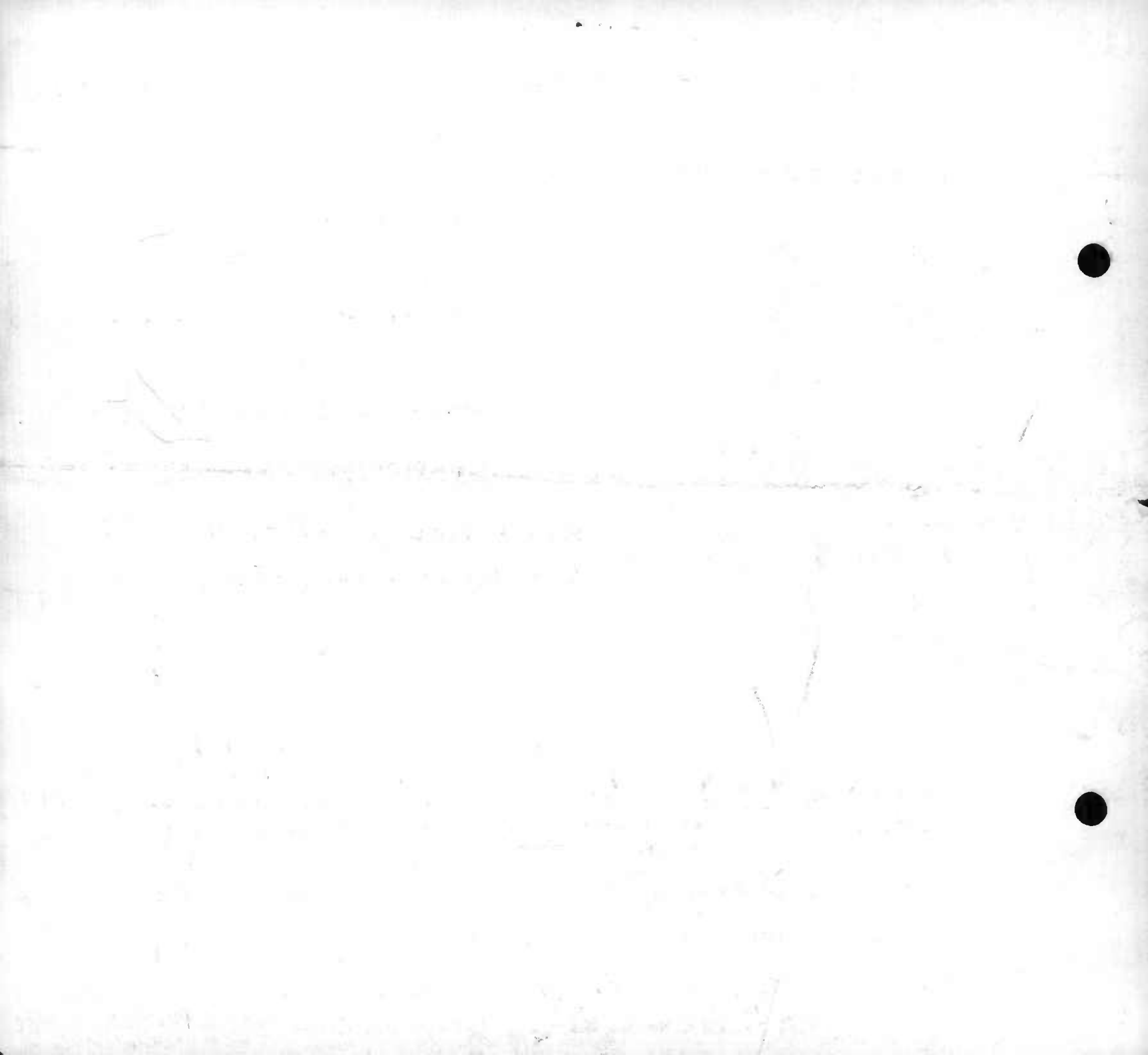
ALBANY, N.Y. 12208

ALBANY, N.Y. 12208

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2198 | |
|--|--|--|--|---|--|
| BIRTH NO. | | 2198 | | 71 | |
| 1. NAME OF DECEASED (Type or Print) | | LILLIAN G. NUTTER | | 2. DATE AND HOUR OF DEATH Feb. 21, 1971 4:50 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F | | 6. RACE N | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 10/28/98 | | 9. AGE (In years last birthday) 72 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland, Co. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs.. Anna Ridgley-Niece 4214 Fairview Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD GARDIOPULMONARY ARREST | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2nd degree burns (25%) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 2nd degree burns (25%) | | 21. MEDICAL CERTIFICATION | | | |
| 21A. DATE OF OPERATION 2 | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No) YES | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 1 21 71 9:30 am | | 21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) nursing home | | 21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Georg Washington Nursing Home | |
| 21G. HOW DID INJURY OCCUR? Scalded by hot water while bathing | | 21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | |
| 22. I certify that (X) (this hospital) attended the deceased from JAN. 21, 1971 to FEB. 21, 1971 that (we) last saw the deceased alive on FEB. 21, 1971 and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Christos Dibranos, M.D. | | 23B. DATE SIGNED FEB. 21, 71 | |
| 23C. PHYSICIAN'S NAME (Type) CHRISTOS N.H.N. DIBRANOS, M.D. | | 23D. ADDRESS PROVIDENT HOSPITAL, 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/25/71 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park | |
| 24D. LOCATION (City, town, or county) (State) Arbutus Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 5 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Joseph L. Russ | | 25D. ADDRESS 2222 W. North Ave Baltimore, Md | | | |



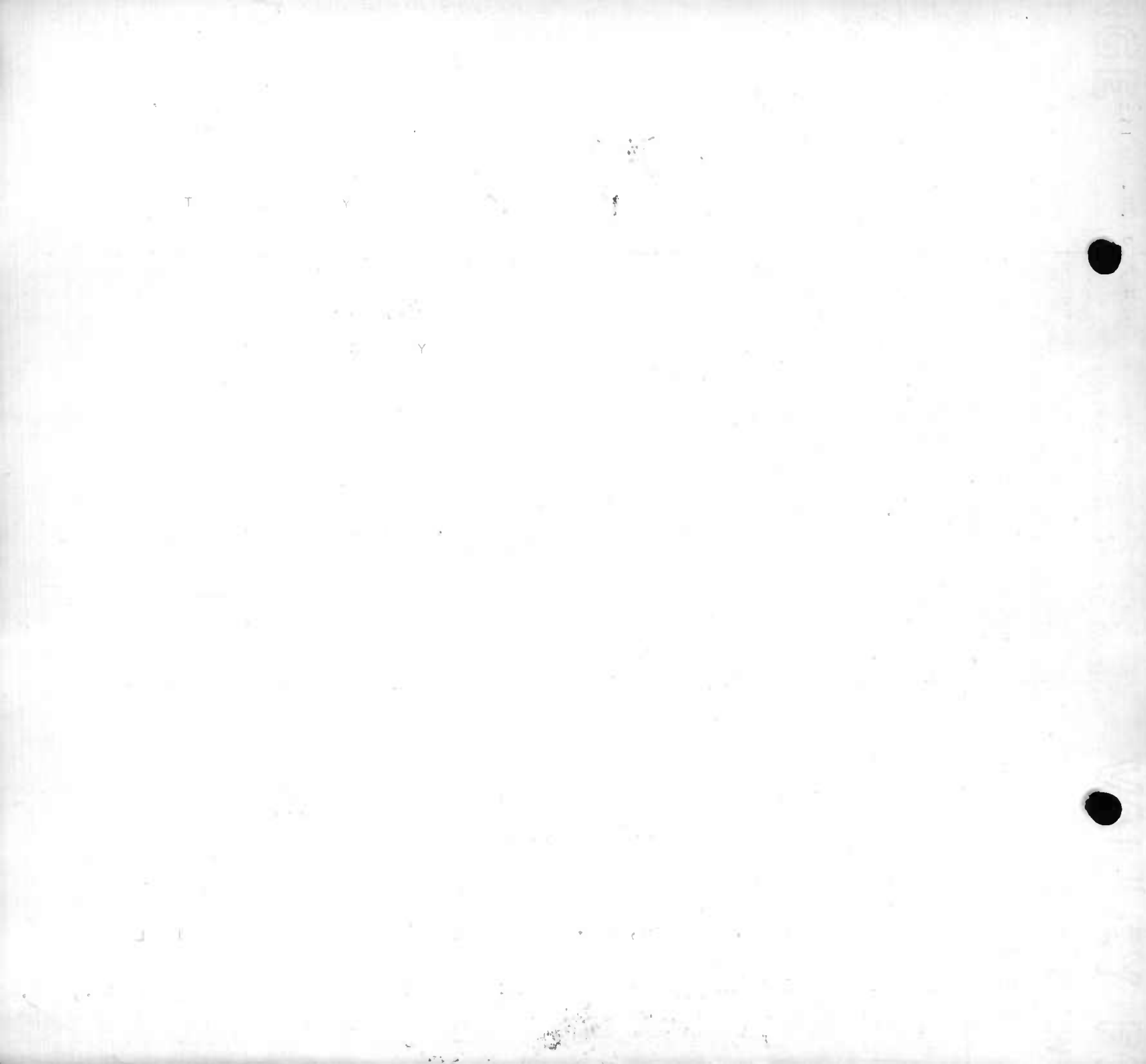
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 71 2199

| | | | | | |
|--|------------------|---|--------------------------|--|---|
| BIRTH NO. 71-02933 | | 1. NAME OF DECEASED (Type or Print) BABY BOY CHENG | | 2. DATE AND HOUR OF DEATH 3:25PM 3/1/71 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto. 5300 | |
| FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 9501 PERRY BROOK COURT | | | | | |
| 5. SEX M | 6. RACE ORIENTAL | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/15/71 | 9. AGE (In years lost birthday) 10 days | If Under 1 Yr. Months: Days: Hours: Min. 10 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Sinai Hospital Balto., MD. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME MING CHENG | | 14. MOTHER'S MAIDEN NAME AMY YANG | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 747.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH Intra operative death (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Patent ductus arteriosus - pre-ductal (B) Coarctation of aorta, transposition of great vessels DUE TO, OR AS A CONSEQUENCE OF: (C)..... | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 days p. birth | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 1/31/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PDA - Coarctation | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 2/15 19 71 to 3/1/71 19 71, that (1) (we) lost saw the deceased alive on 3/1 19 71 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John M. Kellum, Jr. | | | | 23B. DATE SIGNED 3/1/71 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN M. KELLUM, JR. | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3/2/71 | | 24C. NAME of CEMETERY or CREMATORY Johns Hopkins Hospital | |
| 24D. LOCATION (City, town, or county) (State) 601 N Broadway Balto., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 5, 1971 | | 25B. NAME OF REGISTRAR Robert E. Kelly, R.D. | | 25C. FUNERAL DIRECTOR ADDRESS 2190 not an ME case In Spitz - ME Office | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

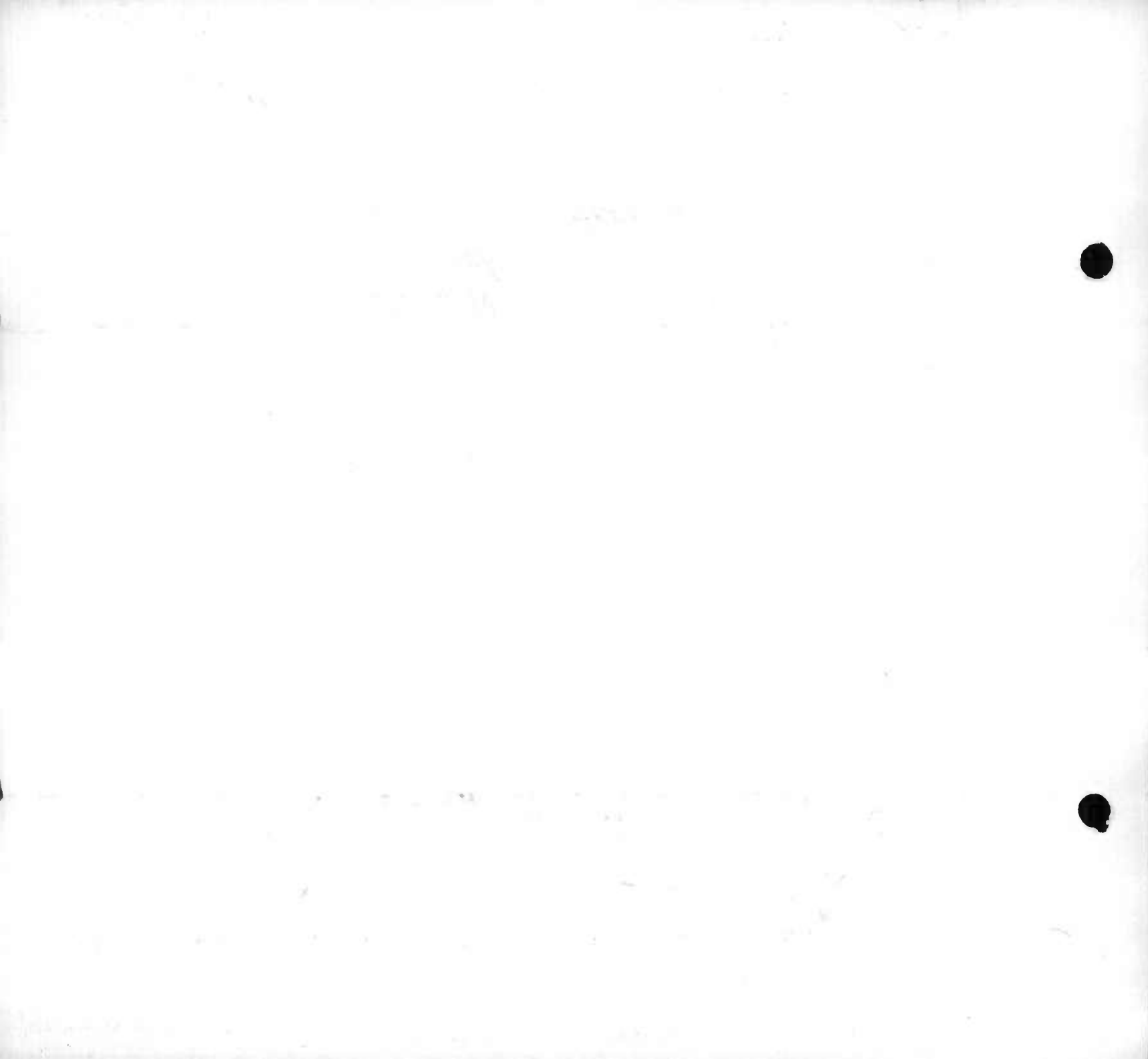
| BIRTH NO. 71 2200 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 71 2200 | | |
|---|-------------------------|---|--|--|--|--|--|---|---------|--|
| 1. NAME OF DECEASED (Type or Print) <u>Christine Gere</u> | | | | 2. DATE AND HOUR OF DEATH <u>1 March 1971</u> <u>2:45 P</u> M. | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if in institution; residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u> | | | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | A. STATE <u>MARYLAND</u> | | B. COUNTY <u>2739</u> | | |
| | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| | | | | E. STREET AND NUMBER <u>1307 PENTWOOD RD.</u> | | | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-18-49</u> | | 9. AGE (In years last birthday) <u>21</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <u>ANSEL GERE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CLARA PORTER</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | |
| 18. <u>0-38-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Staphylococcal aureus sepsis + pneumonia</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Congenital cleft mitral valve and atrial septal defect corrected surgically</u> | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <u>0 1956</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>21 February</u> 19 <u>71</u> to <u>1 March</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1 March</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>Gary M. Kammer MD</u> | | | | DEGREE <u>MD</u> | | 23B. DATE SIGNED <u>1 March 1971</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Gary M Kammer MD</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>3/2/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS UNIV.</u> | | 24D. LOCATION (City, town, or county) (State) <u>ANATOMY BALTO., MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 5 1971</u> | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor MD</u> | | 25C. FUNERAL DIRECTOR <u>JOHNS HOPKINS MED SCHOOL, BALTO, MD</u> | | 25D. ADDRESS | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| G-450 | | 71 2201 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2201 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) GILLIAM MR. JOSEPH D. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH MARCH 5 11 5:15 AM | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2001 | | C. CITY OR TOWN BALTIMORE | |
| 5. SEX MALE | | 6. RACE NEGRO | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/24/23 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BALTIMORE CITY HOSPITAL | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) 47 | | 11. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min. | |
| 13. FATHER'S NAME HENSON HILL | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 230-14-1414 | | 17. INFORMANT HOSPITAL CHART | | ADDRESS | |
| 18. 43601 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Massive CVA (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days years | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 4 19 71 to March 5 19 71 that (I) (we) last saw the deceased alive on March - 5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Young Jai Lee | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED March-5 1971 | |
| 23C. PHYSICIAN'S NAME (Type) YOUNG JAI LEE | | | | 23D. ADDRESS Bon Secours Hosp. BAL. Md 21223 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-5-71 | | 24C. NAME of CEMETERY or CREMATORY MT AUBURN | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Charles W. Hayes | | ADDRESS 3112 Reisterstown Rd | |



FUNERAL DIRECTOR: IMPORTANT

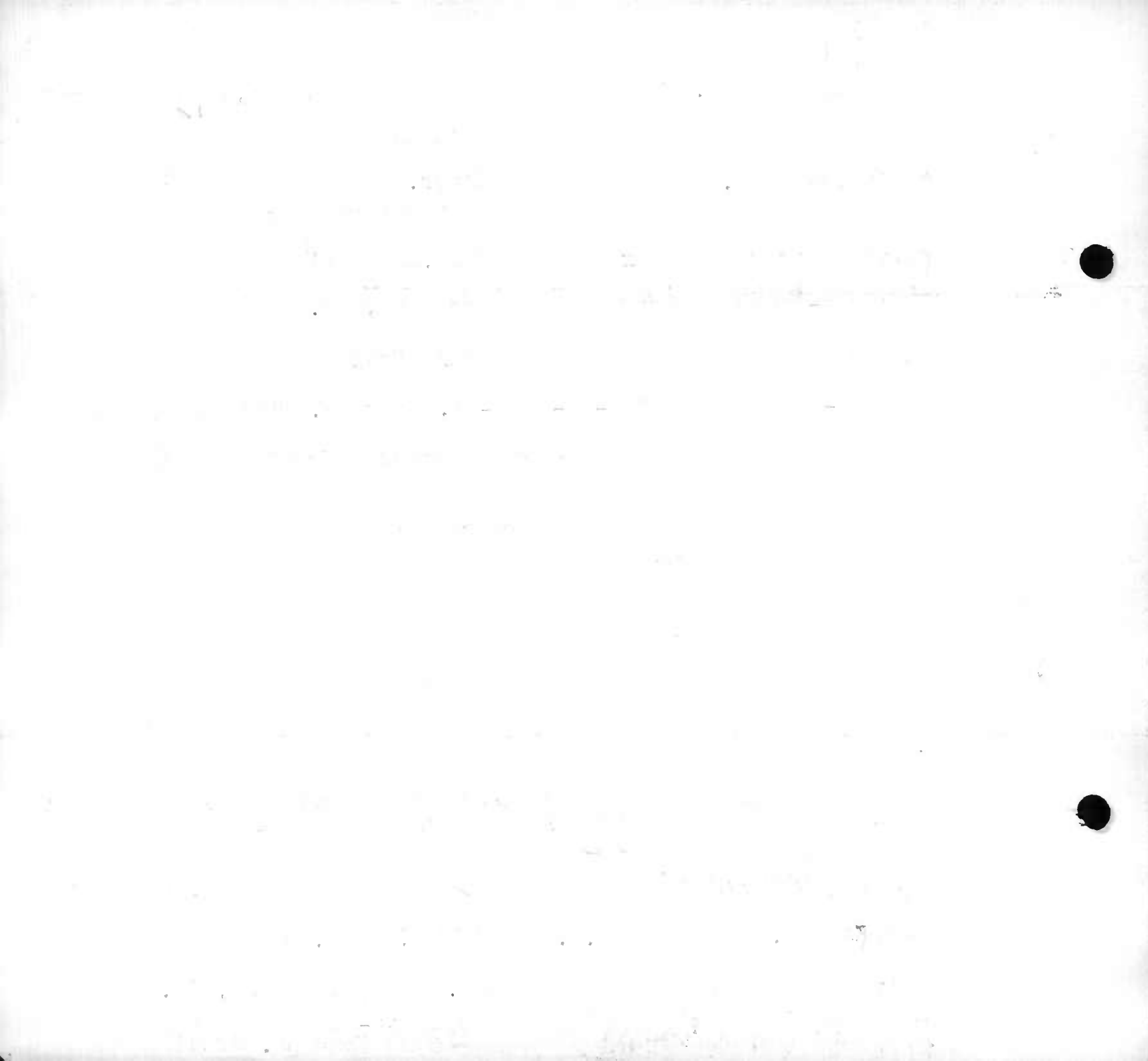
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>K-450</u> <u>71</u> <u>2202</u> | | | | BALTIMORE CITY HEALTH DEPT. | | CERTIFICATE OF DEATH | | REG. NO. <u>71</u> <u>2202</u> | |
|---|--|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>Vincent Keelan</u> | | | | 2. DATE AND HOUR OF DEATH <u>2/27/71</u> <u>7:38 pm</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u> <u>Mercy Hospital, INC.</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | 4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2711</u> | | C. CITY OR TOWN <u>Balto.</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX <u>M</u> | | | | 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11/2/90</u> | |
| 9. AGE (In years last birthday) <u>80</u> | | | | 10. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 11. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Priest</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>SOCIETY OF JESUS</u> | | | | | |
| 13. FATHER'S NAME <u>Thomas A. Keelan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Leonard</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>215-54-2866</u> | | 17. INFORMANT <u>REV. JAS. MC ANDREWS 4501 N. CHAELES</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Constrictive heart failure</u> <u>arteriosclerotic heart disease</u> <u>fracture of left femur</u> | | | | 18. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5T</u> | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> | | | | | | | | | |
| 19A. DATE OF OPERATION <u>None</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner) <u>Broken hip 2/26/71</u> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 21C. WHERE DID INJURY OCCUR? <u>Chas & Cold Spring Lane</u> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>Feb 27 1971</u> | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>fell</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb 26</u> 19 <u>71</u> to <u>Feb 27, 71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Feb 27 1971</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>H.E. Bondy M.D.</u> | | | | 23B. DATE SIGNED <u>Feb 28 '71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>H.E. Bondy</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 24B. DATE <u>3/3/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>WOODSTOCK CEMETERY</u> | | 24D. LOCATION (City, town, or county) (State) <u>WOODSTOCK, MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>MITCHELL-WIEDEFELD HOME</u> ADDRESS <u>6500 YORK RD</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2203 | |
|--|--|--|---|--|---|
| <div style="display: flex; justify-content: space-between;"> B-634 71 2203 X </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) ELIZABETH G. BURDELL </div> <div> 2. DATE AND HOUR OF DEATH MARCH 2ND, 1971 12 P M. </div> </div> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BROADVIEW APTS. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE & COUNTY MARYLAND C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 503 HILLEN ROAD | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/15.1903 | 9. AGE (in years last birthday) 67 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMPANION-NURSE |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMPANION-NURSE | | | 10B. KIND OF BUSINESS OR INDUSTRY SELF | | 11. BIRTHPLACE (State or foreign country) RICHMOND, VA. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME FRANK GAFF | | |
| 14. MOTHER'S MAIDEN NAME SARAH BIBB | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 225-07-0628 | | | 17. INFORMANT MR. EDWIN T. BURDELL (SON) | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ARTERIOSCLEROTIC HEART DISEASE (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GENERALIZED ARTERIOSCLEROSIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div> | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="display: flex; justify-content: space-between;"> <div> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). </div> </div> | | | | | |
| 19A. DATE OF OPERATION NO | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) NO | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? NO | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JUN 7 1968 to MAR 2 1971 that (I) last saw the deceased alive on JAN 21 1971 and that in (my) opinion death occurred on the date MAR 2 1971 and hour and from the causes stated above. (I) (this hospital) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE T. C. Siwinski | | | | 23B. DATE SIGNED 4 MAR 71 | |
| 23C. PHYSICIAN'S NAME (Type) THADDEUS C. SIWINSKI M.D. | | | | 23D. ADDRESS 206 W. PENN. AVENUE TOWSON | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/5/71 | | 24C. NAME OF CEMETERY or CREMATORY FOREST LAWN CEM. | |
| 24D. LOCATION (City, town, or county) (State) RICHMOND, VA. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR MITCHELL WIEDEFELD HOME | | | |
| 25D. ADDRESS 6500 YORK RD. 21212 | | VS 150-REV. 1/768 | | | |



FUNERAL DIRECTOR: IMPORTANT

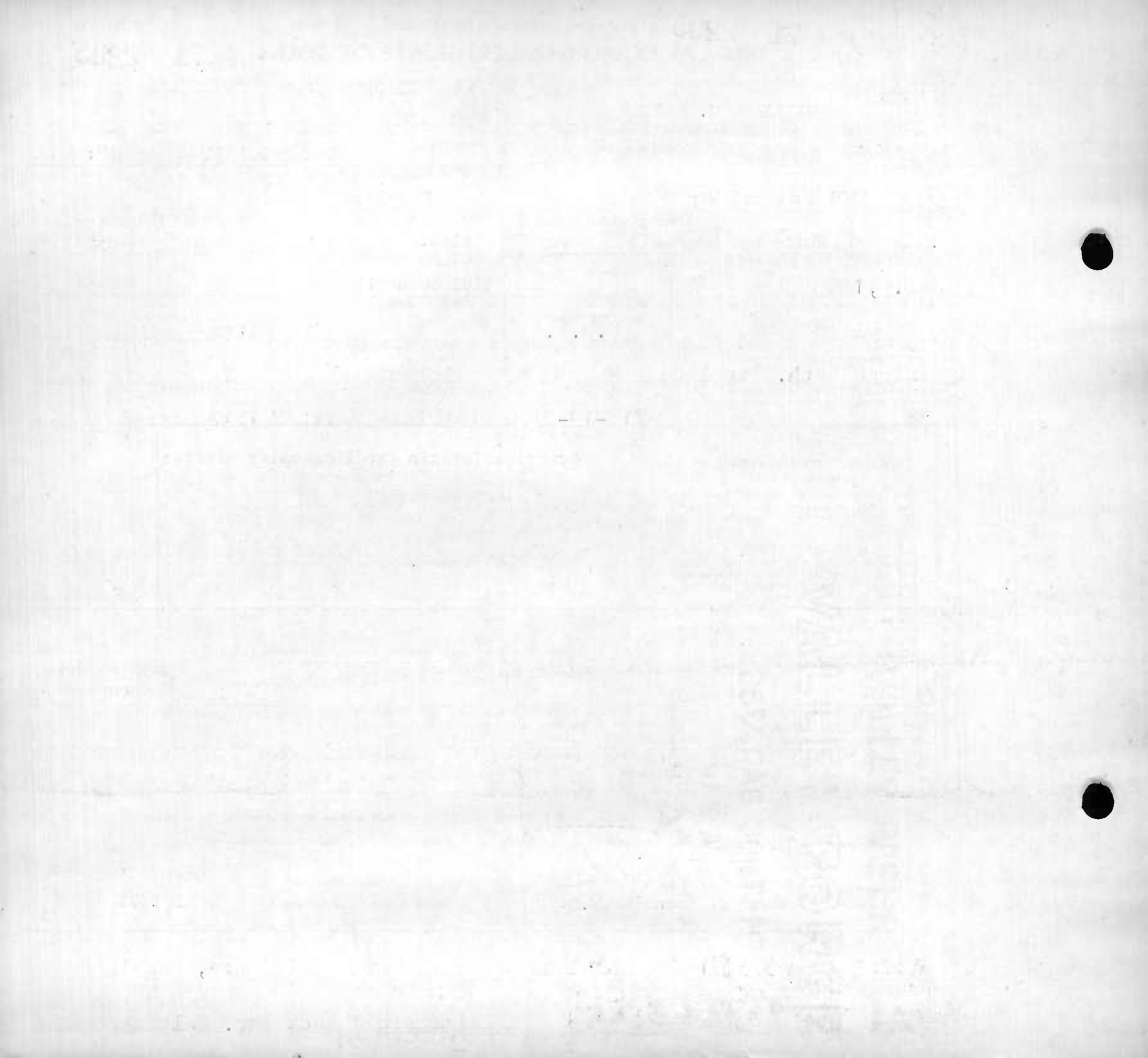
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. _____ | |
|--|------------------|--|---|--|---|
| W-652 71 2204 | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Ernacia William Werring | | March 4, 1971 6: P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 | | | A. STATE Maryland | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | B. COUNTY | | |
| 99 Union Memorial Hospital (D.O.A.) | | | C. CITY OR TOWN Baltimore | | |
| | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER 4017 Echodale Ave | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 8, 1907. | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Manager | | 10B. KIND OF BUSINESS OR INDUSTRY Welsbach Corp. | | 11. BIRTHPLACE (State or foreign country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Rudolph Werring | | | |
| 14. MOTHER'S MAIDEN NAME Freida Grimm | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 63-05-7428 | | 17. INFORMANT Mrs. Ruth Werring | | | |
| ADDRESS (Same) | | 18. CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-13-1965 to 2-28-1971 that (I) (we) last saw the deceased alive on 2-28-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Sebastian Russo</i> | | | | 23B. DATE SIGNED 3/5/71 | |
| 23C. PHYSICIAN'S NAME (Type) Sebastian Russo MD | | | | 23D. ADDRESS 5017 Harford Rd Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/71. | | 24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | |
| 25B. NAME OF REGISTRAR Leonard J. Buck Inc. | | 25C. FUNERAL DIRECTOR Baltimore, Md. | | | |

to my first school

W. S. H. H.

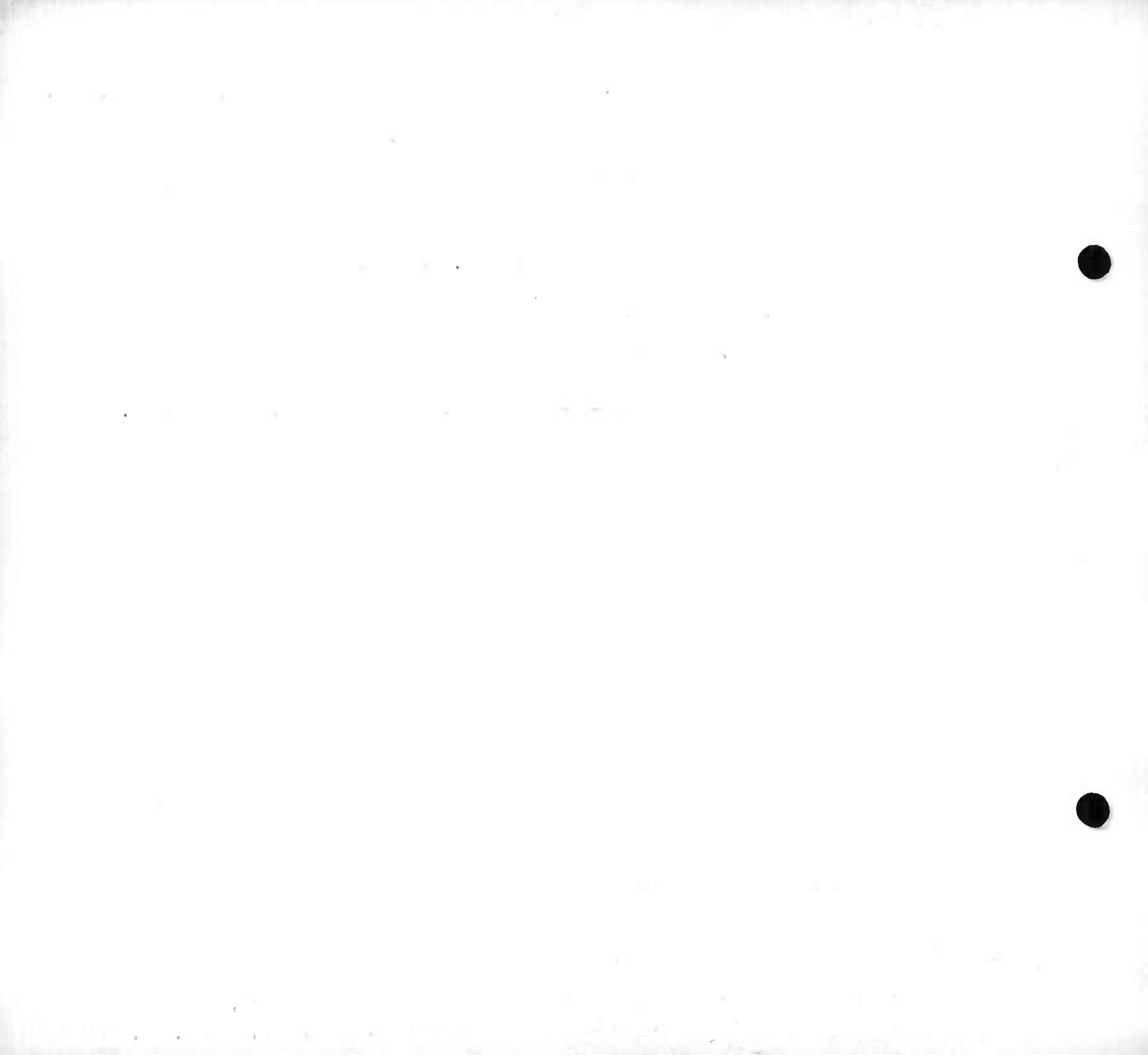
| BIRTH NO. | | REG. NO. | |
|---|--|--|--|
| R-320 71 2205 | | 71 2205 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | |
| WILLIAM G. RITES | | Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 3. DATE PRONOUNCED DEAD | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1101 Quantril Way | | Month Day Year March 3, 1971 | |
| 6. SEX | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| Male | | A. STATE Maryland B. COUNTY 2634 | |
| 7. RACE | | C. CITY OR TOWN | |
| White | | Balto. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | D. INSIDE CITY LIMITS? | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH | | E. STREET AND NUMBER | |
| Jan. 9, 1898 | | 1101 Quantril Way | |
| 10. AGE (In years last birthday) | | 11. BIRTHPLACE (State or foreign country) | |
| 73 | | Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| U.S.A. | | ? Rites | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME | |
| Retired Beth. Steel Co | | Florence ? | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| No | | 213-10-9576 | |
| 18. INFORMANT | | ADDRESS | |
| Patricia M Rites | | 1317 Bonsal St #24 | |
| 19. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | Arteriosclerotic cardiovascular disease | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) | | | |
| 20A. DATE OF OPERATION | | 21. AUTOPSY? (Yes or No) | |
| 0 | | no | |
| 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED | |
| (APPROX.) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Ronald N. Kornblum, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED | | 3/3/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| Burial | | 3/5/71 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Moreland Memorial Park | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| 3/5/71 | | Leonard J. Ruck Inc. Baltimore Md | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |
| | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2206</u> | |
|---|-------------------------|---|--|---|---|
| 71 2206 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. <u>H-252</u> | | 1. NAME OF DECEASED (Type or Print) <u>LAWRENCE E. HAWKINS</u> | | 2. DATE AND HOUR OF DEATH <u>March 3, 1971.</u> <u>12.50 P.</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2634</u> | | | |
| | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>1265 Armistead Way</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 9, 1915.</u> | 9. AGE (in years last birthday) <u>56</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisher Body Co.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>General Motors</u> | | 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Edward L. Hawkins</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Martha Kincaid</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>16. SOCIAL SECURITY NO. 216-30-4072</u> | | | |
| 17. INFORMANT <u>Mrs. Rosalie Grimes, Thurmont, Md.</u> | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> I <u>Myocardial Infarction</u> II <u>Arteriosclerosis - Emphysema</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>Feb 18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Feb 18</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Marcus Levin</u> | | 23B. DATE SIGNED <u>3.4.71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>MARCUS LEVIN</u> | |
| 23D. ADDRESS <u>201 WISE AVE # 22</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 24B. DATE <u>3/6/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

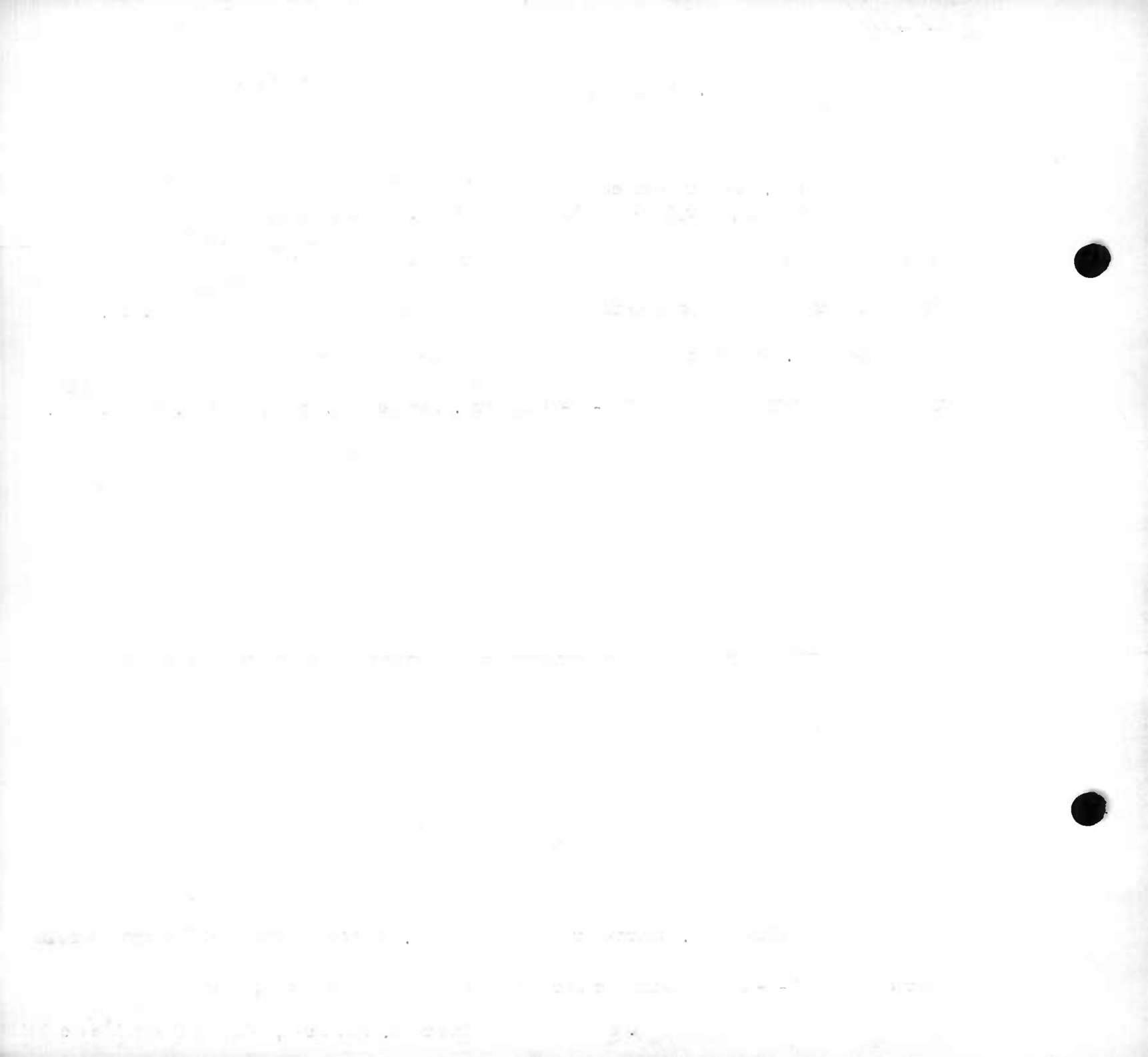
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>12 2207</u> | |
|--|---------------------|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>FRANK J. TOSCHES</u> | | 2. DATE AND HOUR OF DEATH <u>MARCH 4, 1971</u> <u>1510</u> <u>0</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u> | | A. STATE <u>MD</u> B. COUNTY <u>2748</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE, MD</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>5620 SAGRA ROAD</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>JULY 1, 1913</u> | 9. AGE (In years last birthday) <u>57</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>AIR CRAFT</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTO.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>JOHN TOSCHES</u> | | 14. MOTHER'S MAIDEN NAME <u>CLARA Folio</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218 03 1378</u> | | 17. INFORMANT <u>XXXXX Mrs Charlotte Tosches</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Right cerebral infarct - massive</u> | | CAUSE OF DEATH <u>Cardiac arrest</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO <u>Progressive Cardiovascular disease</u> | | <u>2</u> | |
| | | (B) DUE TO <u>Cerebral vascular accident</u> | | <u>2</u> | |
| | | (C) DUE TO <u>Hypertensive Cardiovascular disease</u> | | <u>renal atrophy</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Aspiration pneumonia</u> | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Mar 3</u> 19 <u>71</u> to <u>March 4</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>March 4</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Jae H. Hong</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <u>Mar. 4 '71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JAE H. HONG</u> M.D. | | | | 23D. ADDRESS <u>Maryland General Hospital, Baltimore</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/8/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Most Holy Redeemer</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> | | 24E. STATE <u>Md</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>2442-267</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc. Baltimore, Md</u> | |
| 25D. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

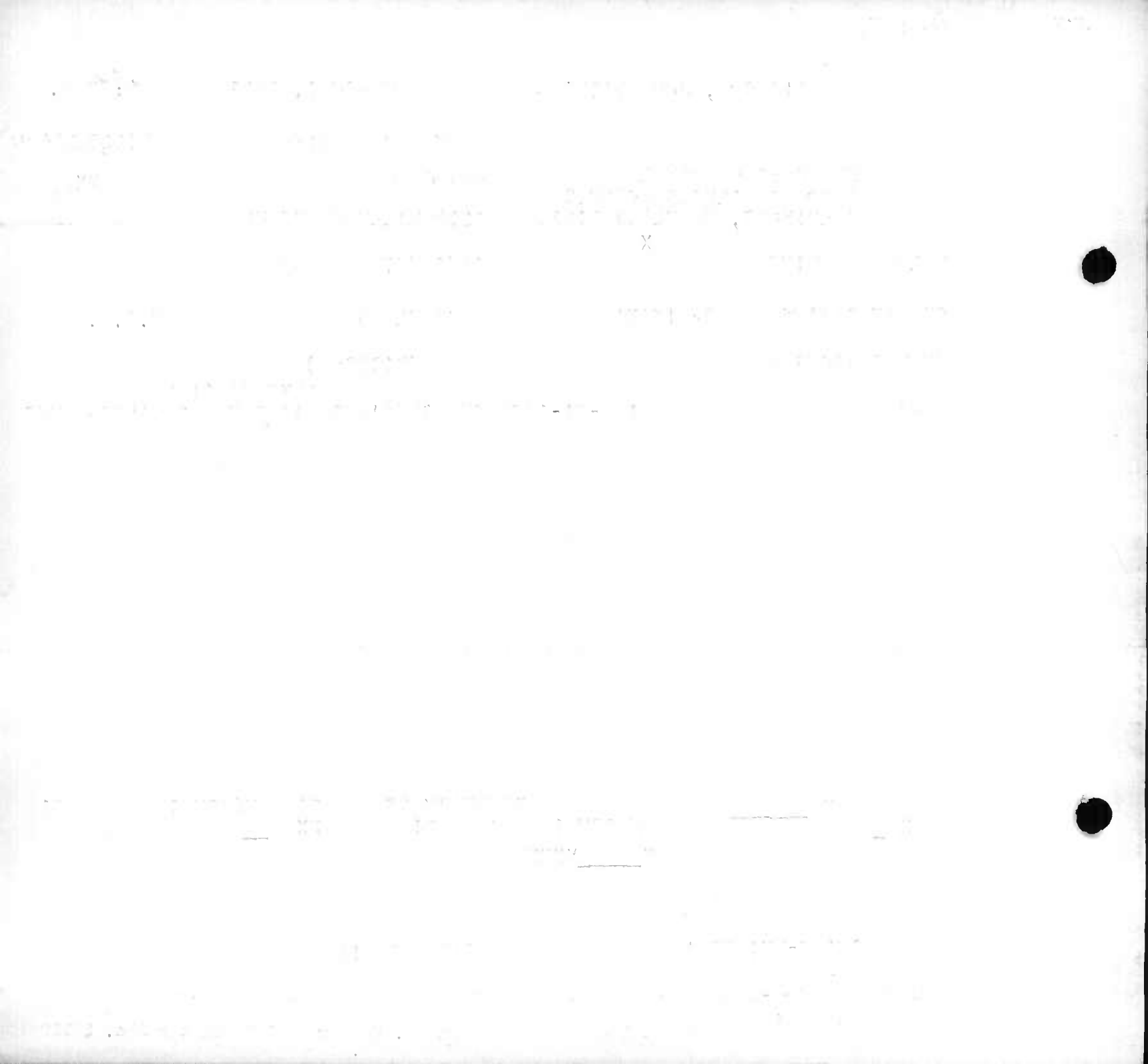
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2208 | | REG. NO. | |
|--|-------------------------|---|--|---|--|--|---|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) HAROLD E. HALVORSEN | | | | 2. DATE AND HOUR OF DEATH March 1, 1971 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1825 W. Lombard Street Baltimore, Maryland 21223 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY 1903 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1825 W. Lombard Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH March 1, 1923 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | | 10B. KIND OF BUSINESS OR INDUSTRY Baltimore City | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Alfred O. Halvorsen | | | | 14. MOTHER'S MAIDEN NAME Jennie Robinson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes W W II | | 16. SOCIAL SECURITY NO. 215-16-9261 | | 17. INFORMANT Mrs. Jennie Halvorsen, 1825 W. Lombard St. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Arterio-sclerotic heart disease</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs. | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 1958 to March 1 1971 that (I) (we) last saw the deceased alive on Feb. 21 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Morris B. Schreiber</i> DEGREE | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-2-71 | |
| 23C. PHYSICIAN'S NAME (Type) Morris B. Schreiber DEGREE | | | | 23D. ADDRESS 1519 W. Lombard Street, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-1971 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Howe E. Hubbard | | 25C. FUNERAL DIRECTOR Howard H. Hubbard | | ADDRESS 4107 Wilkens Avenue 21229 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|---|--|---|---|
| BIRTH NO. 71 2209 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2209 | |
| 1. NAME OF DECEASED (Type or Print) DICKSON, JOHN DICKSON | | | 2. DATE AND HOUR OF DEATH MARCH 1, 1971 4:00 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN Lansdowne D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3214 HILLTOP AVENUE | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/19/07 | 9. AGE (In years last birthday) 63 | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STREET CLEANER | | 10B. KIND OF BUSINESS OR INDUSTRY SANITATION | | 11. BIRTHPLACE (State or foreign country) SCOTLAND | |
| 13. FATHER'S NAME THOMAS DICKSON | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 14. MOTHER'S MAIDEN NAME ANN (DICKSON) | | |
| 16. SOCIAL SECURITY NO. 188-01-1658 | | 17. INFORMANT BALTO MD 21229 ADDRESS ST AGNES' RECORDS CATON & WILKEN AVES | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial infarction Arteriosclerotic cardiovascular disease Hypertension | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Recurrent Epistaxis | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 25 19 71 to MARCH 1 19 71 that (I) (we) last saw the deceased alive on MARCH 1 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Tse-Shiung Wu | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) CHING-HUI TSAI | | | | 23D. ADDRESS CATON & WILKENS AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-1971 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Howard H. Hubbard ADDRESS 4107 Wilkens Ave. 21229 | |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | | | | REG. NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) STEVEN L. SIMPSON | | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 2 28 71 12:05 P.M. | | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital | | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 28 71 12:05 P.M. | | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore | | | | | | | | | |
| 6. SEX male | | 7. RACE White | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH 9-10-1954 | | 10. AGE (In years lost birthday) 16 | | 11. BIRTHPLACE (State or foreign country) Maryland | | E. STREET AND NUMBER 4507 Linden Avenue | | | |
| 12. CITIZEN OF U.S.A. | | 13. FATHER'S NAME Bruce C. Simpson | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 15. MOTHER'S MAIDEN NAME Regina L. Miller | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 214-54-0879 | | 18. INFORMANT Mr. Bruce Simpson, Sr. | | 19. CAUSE OF DEATH Craniocerebral injuries | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) no | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rolling Ave. & Wilkens Ave. | | 22D. TIME OF INJURY (APPROX.) Month Day Year Hour Min. 2 26 71 11:14 P.M. | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Subject was a passenger in auto which struck a tree. | | | | | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/1/71 | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-1971 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Howard H. Hubbard | | ADDRESS 4107 Wilkens Ave. 21229 | | | |

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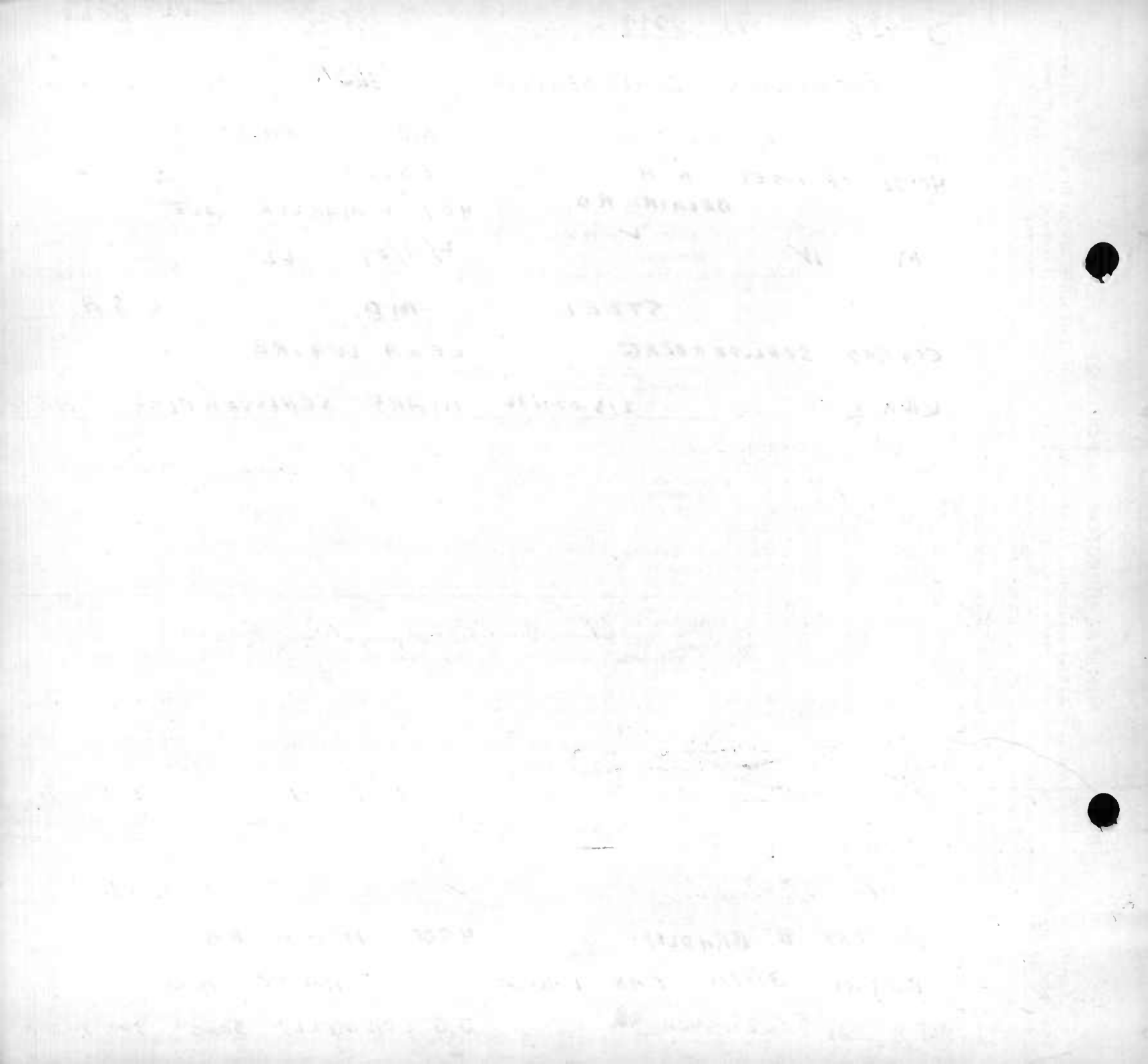
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

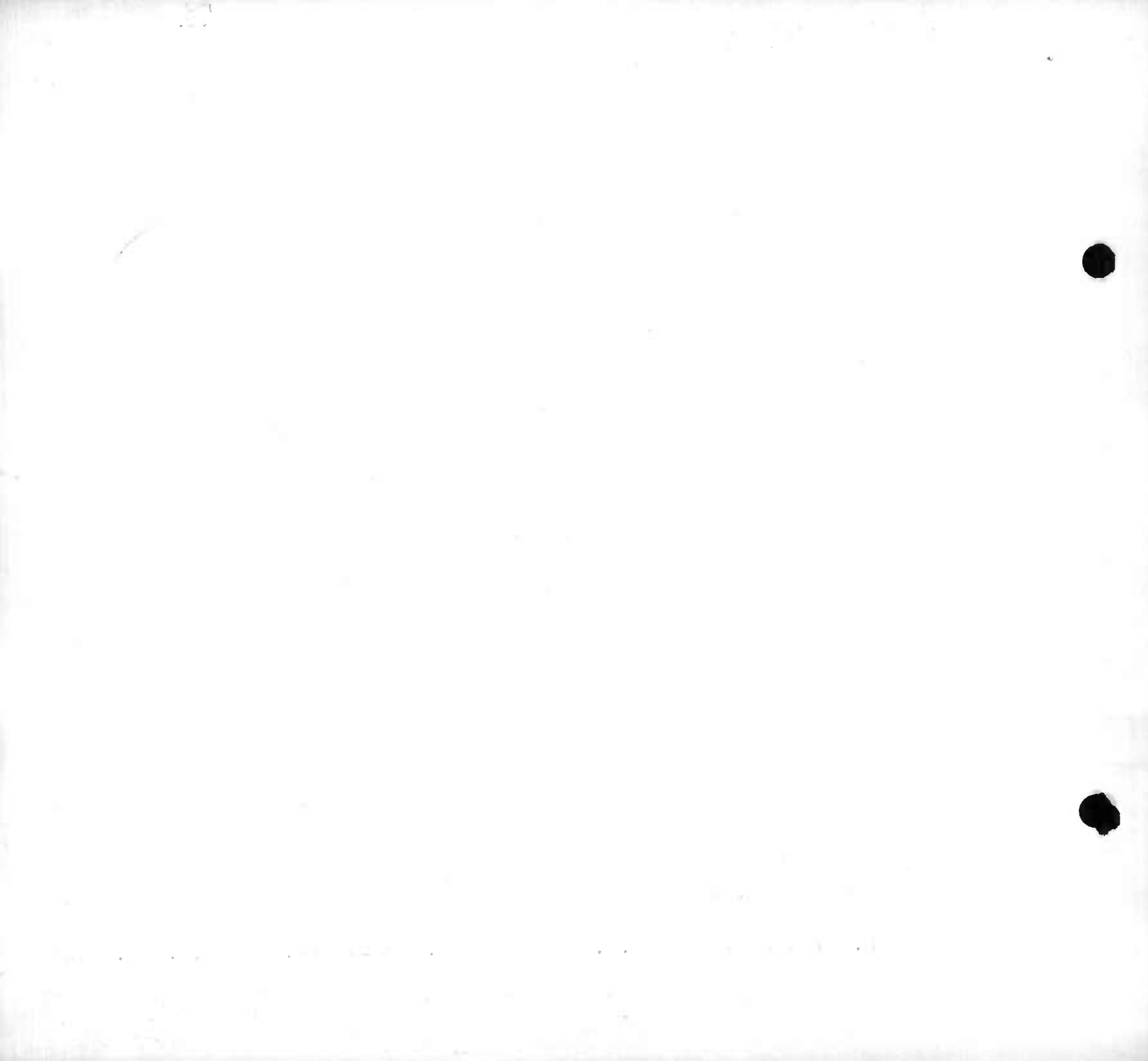
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2211 | | REG. NO. 71 2211 | |
|--|--|---|--|---|--|--|--|
| S-436 BIRTH NO. 1. NAME OF DECEASED (Type or Print) FREDERICK SCHLUDERBERG | | | | 2. DATE AND HOUR OF DEATH MAR 3 1971 2:55 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOUSE OF PINES N.H. 90 BELAIR RD. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. 5300 C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 407 S. MARLYN AVE. | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/9/09 | |
| 9. AGE (In years last birthday) 62 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL | | 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CONRAD SCHLUDERBERG | | | | 14. MOTHER'S MAIDEN NAME LENA WAIRE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK | | | | 16. SOCIAL SECURITY NO. 213-07-1836 | | 17. INFORMANT MARY SCHLUDERBERG ABOVE ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, gunshot, etc. It means the disease, injury or complication which caused death.) 485X 3/3/71 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic Bronchitis, Emphysema, Uremia, Pyelonephritis | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > a week | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 3/2/1971 to 3/5/1971 that (I) (me) last saw the deceased alive on 3/2/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | 23A. SIGNATURE Albert B. Bradley DEGREE | |
| 23B. DATE SIGNED 3/5/71 | | 23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY DEGREE | | 23D. ADDRESS 4900 BELAIR RD | | 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | |
| 24B. DATE 3/5/71 | | 24C. NAME OF CEMETERY OR CREMATORY OAK LAWN | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | |
| 25B. NAME OF REGISTRAR Robert E. Gabley, Jr. | | 25C. FUNERAL DIRECTOR J.G. CONNELLY SONS | | ADDRESS 300 MACE | | VS 150-REV. 7/1/68 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

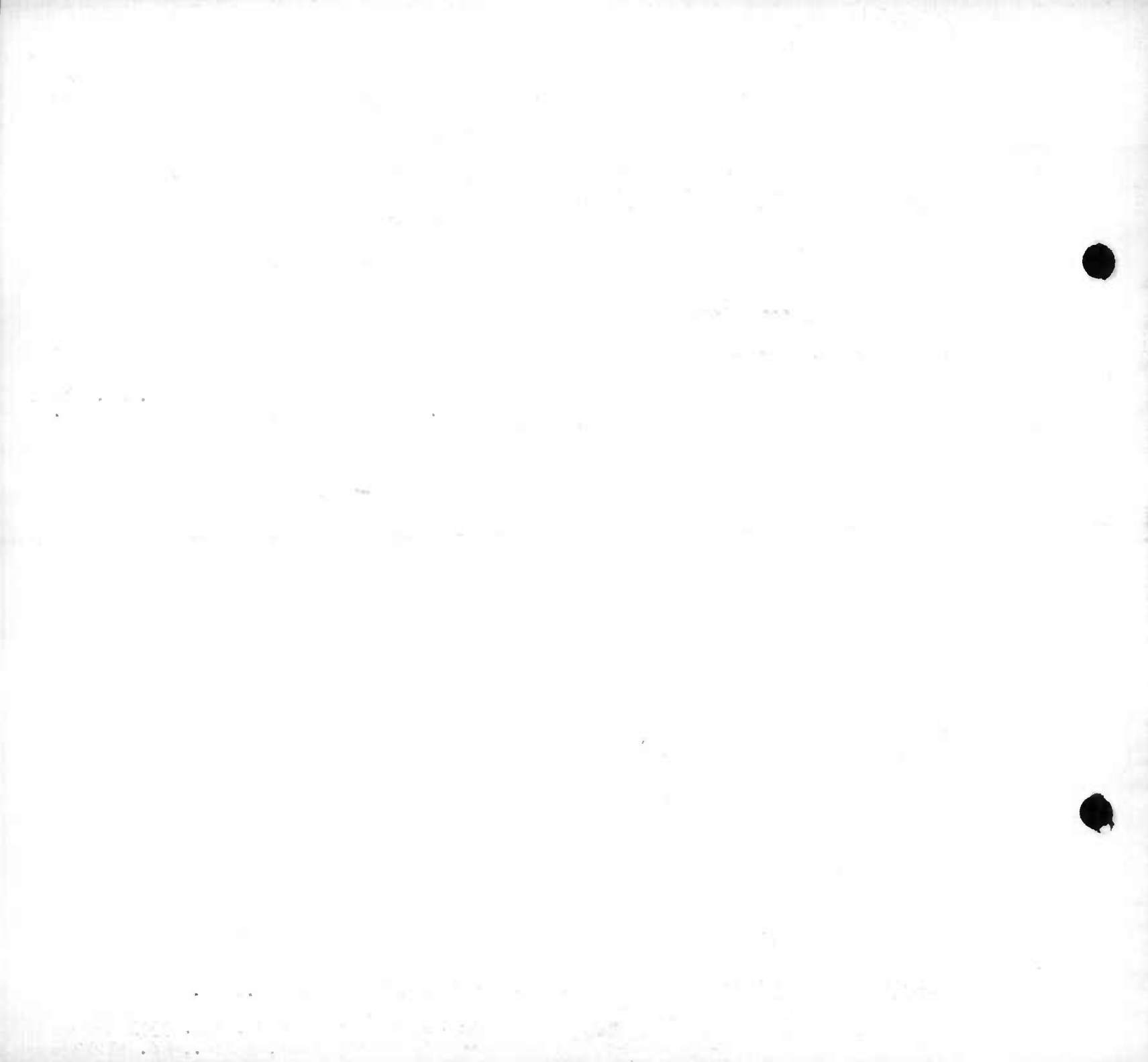
| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | 71 2212 | |
|---|---------|--|------------------|--|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | 71 2212 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| Samuel Uller | | March 4, 1971 6:15 A.M. | | George Washington Nursing Home | | A. STATE Md. Garrett 6500 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | E. STREET AND NUMBER | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX | 6. RACE | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | unknown | 85 ? | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| unknown | | | | unknown | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| unknown | | | | unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | 32054-7141 | | CHART | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| arteriosclerotic heart disease | | | | | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Congestive Heart Disease | | | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | Cardiomegaly | | | | | |
| | | (C) ... | | | | | |
| | | Paranoid Schizophrenia 1909 | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-13-1970 to 3-4-1971 and that (I) (we) lost saw the deceased alive on 2-20-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Richard Tyson, M.D. | | | | 3-4-71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Dr. Richard Tyson M.D. | | | | 936 W. North Ave. | | Balto. Md. 21217 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 3-5-71 | | Mt Calvary | | Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH OFF. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| MAR 8 1971 | | John E. Taylor, JR. | | Mrs. M. C. Brown | | 936 W. North Ave. Balto. Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|--|---------------------|---|--|---|--|---|--|--|--|
| B-350 | | 71 2213 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 71 2213 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) <u>Bettien, William J.</u> | | | | | |
| | | | | 2. DATE AND HOUR OF DEATH <u>3/3/71</u> <u>12³⁰ P.M.</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home & Hospital</u> <u>35 BROADWAY & FAYETTE</u> | | | | C. CITY OR TOWN <u>BALTO.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER <u>32 N. SECKER AVENUE 21224</u> | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>01-20-00</u> | | 9. AGE (In years last birthday) <u>71</u> | | 10. If Under 1 Yr. Months Days | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Adolf Bettien</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY Schupp</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Clara Bettien, 2820 Southbrook Rd.</u> | | | |
| 18. <u>4309173032</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>- GI Bleeding</u> | | | | (A) IMMEDIATE CAUSE <u>CVA (Thrombosis Left)</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> <u>- Subarachnoid hemorrhage</u> (B) <u>- Arteriosclerosis General</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>- Chronic Alcoholism</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/14</u> 19 <u>71</u> to <u>3/3/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>2 PM 3/3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>A.C. Chouvalit, M.D.</u> | | | | DEGREE <u>MD</u> | | 23B. DATE SIGNED <u>3/3/71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>A.C. CHOUVALIT, M.D.</u> | | | | DEGREE <u>MD</u> | | 23D. ADDRESS <u>Church Home & Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>3/6/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. J. [illegible]</u> | | 25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> | | ADDRESS <u>3331 Brehms Lane, Balto., Md. 21213</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

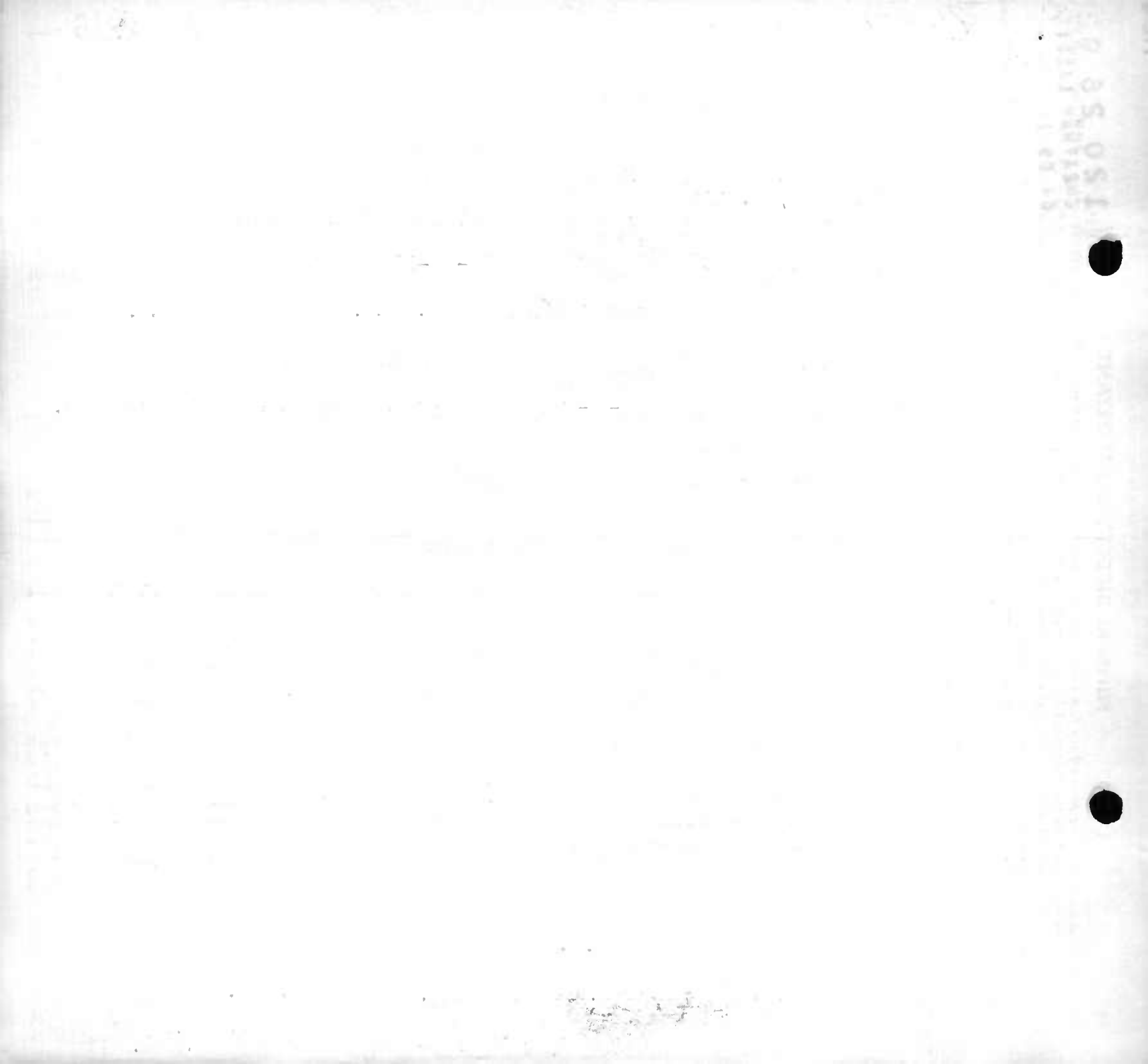
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2214</u> | |
|---|-----------------------------|---|---|--|---|
| C-462 71 2214 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Clark, Catherine</u> | | | 2. DATE AND HOUR OF DEATH <u>March 3, 1971</u> <u>9⁴⁵</u> A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u> <u>38</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>841</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>3232 Elmora Ave</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/7/07</u> | 9. AGE (in years last birthday) <u>63</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>George Rolf</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Whetzel</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <u>Walter Clark, 3232 Elmora Ave., Balto, Md.</u> | | |
| 18. <u>4109 I</u> CAUSE OF DEATH | | | ADDRESS <u>21213</u> | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCD</u> | | |
| | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>2/19</u> 19 <u>71</u> to <u>3/3</u> 19 <u>71</u> that (I) <u>we</u> last saw the deceased alive on <u>3/3</u> 19 <u>71</u> and that in my <u>(au)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> view the body after death. | | | | | |
| 23A. SIGNATURE <u>Lawrence Mills, Jr. MD</u> | | | 23B. DATE SIGNED <u>3/3/71</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Lawrence Mills, Jr.</u> | | | 23D. ADDRESS <u>University Hospital Baltimore, Md.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>3/6/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u> | |
| 24D. LOCATION <u>Balto., Md.</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 24F. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u> | |
| 24G. FUNERAL DIRECTOR <u>Schimunek Funeral Home, 3331 Brehms Lane</u> | | 24H. ADDRESS <u>Baltimore, Md. 21213</u> | | 24I. DATE OF DEATH <u>3/3/71</u> | |



| 1 | | P-620 71 2215 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. 71 2215 | |
|--|--|---------------|--|----------------------------------|---|---|--|------------------|--|
| BIRTH NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) FRANK PRUCHA | | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 3/2/71 M. | | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 830 N. Kenwood Ave. | | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 3 2 1971 4:10 p.m. | | | | |
| 6. SEX male | | | | | 7. RACE white | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 702 | | | | |
| 9. DATE OF BIRTH | | | | | 10. AGE (In years last birthday) 67 | | | | |
| 11. BIRTHPLACE (State or foreign country) Balto., Md. | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stevedor | | | | | 15. MOTHER'S MAIDEN NAME Mary Havlik | | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | | 17. SOCIAL SECURITY NO. none | | | | |
| 18. INFORMANT ADDRESS James F. Prucha, 343 S. East Ave. | | | | | | | | | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fatty metamorphosis of liver | | | | | | | | | |
| 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 21. AUTOPSY? (Yes or No) PARTIAL | | | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | |
| 22F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER(S) NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-3-71 | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | | | | 24B. DATE 3/5/71 | | | | |
| 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | | | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | | | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | | | |
| 25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, 3331 Brehms Lane Baltol, Md., 21213 | | | | | | | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is shown: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

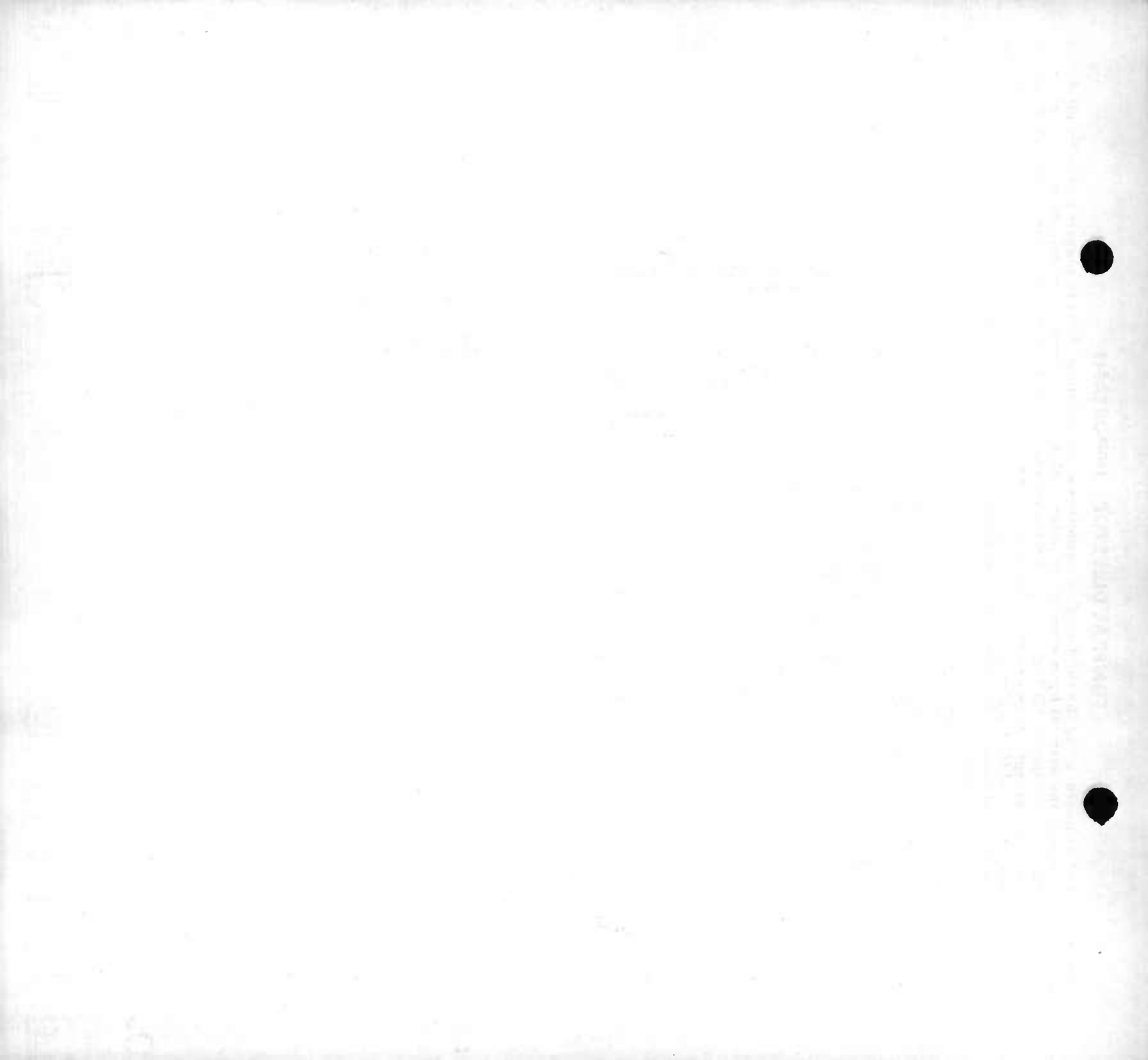
| | | | | | | | |
|---|-------------------------|---|-------------------------------------|---|---|--|--|
| C-350 | | 71 2216 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2216 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Cheatham, William</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>3/2 5:55 AM</i> | | | | M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2632</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i> BALTIMORE, MD. 21205 | | | | C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER <i>4706 BLUE RIDGE AVE</i> | | | | | | | |
| 5. SEX <i>FEMALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>04-09-11</i> | 9. AGE (In years last birthday) <i>59</i> | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Binder</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Schneidereith & sons</i> | | 11. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>JOSEPH DURM</i> | | | | 14. MOTHER'S MAIDEN NAME <i>OLIVIA PURCELL</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>219-40-5744</i> | | 17. INFORMANT (husband) <i>Thomas W. Cheatham, 4706 Blue Ridge Ave.</i> | | ADDRESS | |
| 18. CAUSE OF DEATH <i>1519 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) IMMEDIATE CAUSE <u>Carcinoma of stomach</u></i> <i>(B) DUE TO, OR AS A CONSEQUENCE OF:</i> <i>(C) DUE TO, OR AS A CONSEQUENCE OF:</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 mos</i> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>no</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/1</i> 19 <i>71</i> to <i>3/2</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>3/1</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Greene</i> | | | | 23B. DATE SIGNED <i>3/2/71</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Varlas Greene</i> | | | | 23D. ADDRESS <i>M.D. Johns Hopkins Hosp.</i> | | | |
| 24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <i>burial 3/5/71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Cem.</i> | | 24D. LOCATION <i>Balto., Md.</i> | | (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Galt, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc., 3331 Brehms Lane, Balto., Md.</i> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 2217</u> | |
|---|---------------------|--|--|---|--|--|--|
| BIRTH NO. <u>B-240</u> | | | | 71 2217 | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Edna Bosley</u> | | | | 2. DATE AND HOUR OF DEATH <u>3-2-71</u> <u>12⁰⁵</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>909</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy Hospital</u> | | C. CITY OR TOWN <u>BALTO.</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>1831 HOPE STREET</u> | | | |
| 5. SEX <u>7</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-3-1900</u> | 9. AGE (In years last birthday) <u>70</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 13. FATHER'S NAME <u>TOM JOHNSON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>JO ANN</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>GERTRUDE WHITE 1831 HOPE ST.</u> | | | |
| 18. <u>1621 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Lung</u> (B) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Citroni fibroid</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-25</u> 19 <u>71</u> to <u>3-2</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3-2</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Boo Keun KIM</u> DEGREE | | | | 23B. DATE SIGNED <u>3/2/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Boo Keun KIM</u> DEGREE | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-4-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Mt. CALVARY CEM.</u> | | 24D. LOCATION (City, town, or county) (State) <u>ANNE ARUNDEL CTY., MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>Chloe J. ...</u> | | 25C. FUNERAL DIRECTOR <u>Wm C. MARCH</u> ADDRESS <u>928 E. NORTH AVE</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|--|-----------|--|--|--|---|--|--|---|--|--|
| REG. NO. 71 2218 | | | | | | | | | | | |
| BIRTH NO. 7103668 71 2218 | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) BABY GIRL ROBERTS | | | | | | | | | | | |
| 2. DATE AND HOUR OF DEATH 3-2-71 11:12 AM | | | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| UNIVERSITY OF MARYLAND HOSP. | | | | | | A. STATE MARYLAND | | | | | |
| | | | | | | C. CITY OR TOWN BALTO. | | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | | E. STREET AND NUMBER 2429 W. LAFAYETTE AVE | | | | | |
| 5. SEX F | | 6. RACE N | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-27-71 | | 9. AGE (In years last birthday) 4 | | 10. Under 1 Yr. Months Days 4 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME NORMAN ROBERTS | | | | | | 14. MOTHER'S MAIDEN NAME LAURIE LOUISE ROBERTS | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS LAURA ROBERTS 2429 W. LAFAYETTE | | | |
| 18. 778.21 CAUSE OF DEATH | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| (A) IMMEDIATE CAUSE PULMONARY HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | |
| (B) CONGESTIVE FAILURE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | |
| (C) PREMATURITY | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 27 19 71 to MARCH 2 19 71 that (I) (we) last saw the deceased alive on MARCH 2 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Kenneth Hoffman MD DEGREE | | | | | | | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) KENNETH HOFFMAN DEGREE | | | | | | 23D. ADDRESS UNIVERSITY OF MARYLAND | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 3-5-71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem | | | | 24D. LOCATION (City, town, or county) (State) Balt. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | | | 25C. FUNERAL DIRECTOR ADDRESS 1412 S. MARCH 925 E. NORTH | | | |

address should be 4149 Mountwood Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 71 2218 | |
|---|--|--|---|---|--|--|--|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) L. Ophelia Hall | | | | 2. DATE AND HOUR OF DEATH 3/2/71 11:50 M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc. 2600 Liberty Heights Avenue Baltimore, Maryland 21215 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7128 Walnut Avenue | | | |
| 5. SEX Female | 6. RACE Black | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-1-90 | 9. AGE (In years last birthday) 80 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 11. BIRTHPLACE (State or foreign country) Phila., Pa. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Charles Gilliard | | | | 14. MOTHER'S MAIDEN NAME Rose Hutchinson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-30-0800 | 17. INFORMANT Mrs. Hilda Hall BROWN (Daughter) ADDRESS Same | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Permanent Cardiac Aneurysm 2 weeks | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/2/71 19 71 to 3/2/71 19 71 that (I) (we) last saw the deceased alive on 3/2/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Elijah Saunders | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/4/71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. E. Saunders M.D. | | | | 23D. ADDRESS 2300 Garrison Blvd. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-6-71 | | 24C. NAME of CEMETERY or CREMATORY St Thomas Cemetery | | 24D. LOCATION (City, town, or county) (State) Randallstown, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Wm. C. March | | ADDRESS 928 E. North Ave. | |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2220 | | | |
|---|--|--|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | 71 2220 | | | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) MARGARET EVANS | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M. March 4, 1971 | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2208 Cecil Avenue | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour M. March 4, 1971 5:44 A. | | | |
| 6. SEX Female | | | | 7. RACE Negro | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH 8-29-18 | | | | 10. AGE (In years lost birthday) 52 | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? School | | | | 13. FATHER'S NAME Augro Jones | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 908 | |
| 15. MOTHER'S MAIDEN NAME Mary | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 17. SOCIAL SECURITY NO. 217-07-1027 | | | | 18. INFORMANT ADDRESS Daniel Evans 2208 Cecil Ave. | | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH Hypertensive and arteriosclerotic cardiovascular disease | | | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 22. DATE OF OPERATION 2 | | | | 23. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 26. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 29. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 4, 1971 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 3-8-71 | | | |
| 24C. NAME OF CEMETERY OR CREMATORY St Thomas Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Randallstown, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 Robert E. Fisher | | | | 25B. NAME OF REGISTRAR Wm C March | | | |
| 25C. FUNERAL DIRECTOR ADDRESS 928 E. North Ave. | | | | | | | |

MEMORANDUM FOR THE RECORD

TO : THE CHIEF OF BUREAU OF REVENUE

FROM : THE CHIEF OF BUREAU OF REVENUE

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

1988

WEEKLY REPORT OF THE

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71 2222

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2222

BIRTH NO.

| | | | | | | | |
|--|--|----------------------------|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Thomas Leroy Thuma | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 2 26 71 3:43 p.m. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 43 South Baltimore General | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 26 71 3:43 p.m. | | | |
| 6. SEX male | | | | 7. RACE white | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH Nov. 17, 1902 | | | | 10. AGE (In years lost birthday) 69 | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME unknown | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2401 | |
| 15. MOTHER'S MAIDEN NAME unknown | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 1 | | 17. SOCIAL SECURITY NO. unknown | |
| 18. INFORMANT Doris Thuma | | | | ADDRESS 1471 Woodall Street | | | |
| 19. CAUSE OF DEATH 935X | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20A. DATE OF OPERATION 0 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 21. AUTOPSY? (Yes or No) no | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1471 Woodall St. 2401 | | | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 2 26 71 3:34 p.m. | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? shot self | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. DATE SIGNED 2/27/71 EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/71 | | 24C. NAME OF CEMETERY or CREMATORY Lakeview Memorial Park | | 24D. LOCATION (City, town, or county) (State) Carroll County Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | | 25B. NAME OF REGISTRAR Robert E. Spitz | | 25C. FUNERAL DIRECTOR Mc Cully Funeral Home | |
| | | | | ADDRESS 130 E. Fort Ave. | | | |

VALLEY REPORT CO.

FOR DEPOSIT

of the report from the
small party

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| M-242 71 2223 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2223 | |
|--|------------------|--|-------------------------------------|--|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) McALISTER, Nellie M | | 2. DATE AND HOUR OF DEATH 4 MARCH 71 3:29 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Baltimore - Maryland 2716 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3102 Oakford Avenue | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/22/95 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Henry C. Thompson (dec) | | 14. MOTHER'S MAIDEN NAME Barbara Thompson | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 22-44-2042 | | 17. INFORMANT Chart - North Charles General | |
| 18. 410.0 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) HYPERTENSIVE ATHEROSCLEROTIC DUE TO, OR AS A CONSEQUENCE OF: | | MAN YEARS - | |
| (C) CORONARY VASCULAR DISEASE | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH - 1 19 71 to MARCH 4 19 71 that (I) (we) last saw the deceased alive on MARCH 4 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Arthur B. Jenn II | | | | 23B. DATE SIGNED 4 MARCH 71 | |
| 23C. PHYSICIAN'S NAME (Type) ARTHUR B. JENN II MD | | 23D. ADDRESS NORTH CHARLES GENERAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar. 7, 1971 | | 24C. NAME of CEMETERY or CREMATORY Mt. Carmel Cemetery | |
| 24D. LOCATION Parkton, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | |
| 25B. NAME OF REGISTRAR W. J. Schlegel | | 25C. FUNERAL DIRECTOR W. J. Schlegel | | | |

2-10-1911
1911

First Charles Edward Wright

7 10 1910/12 72

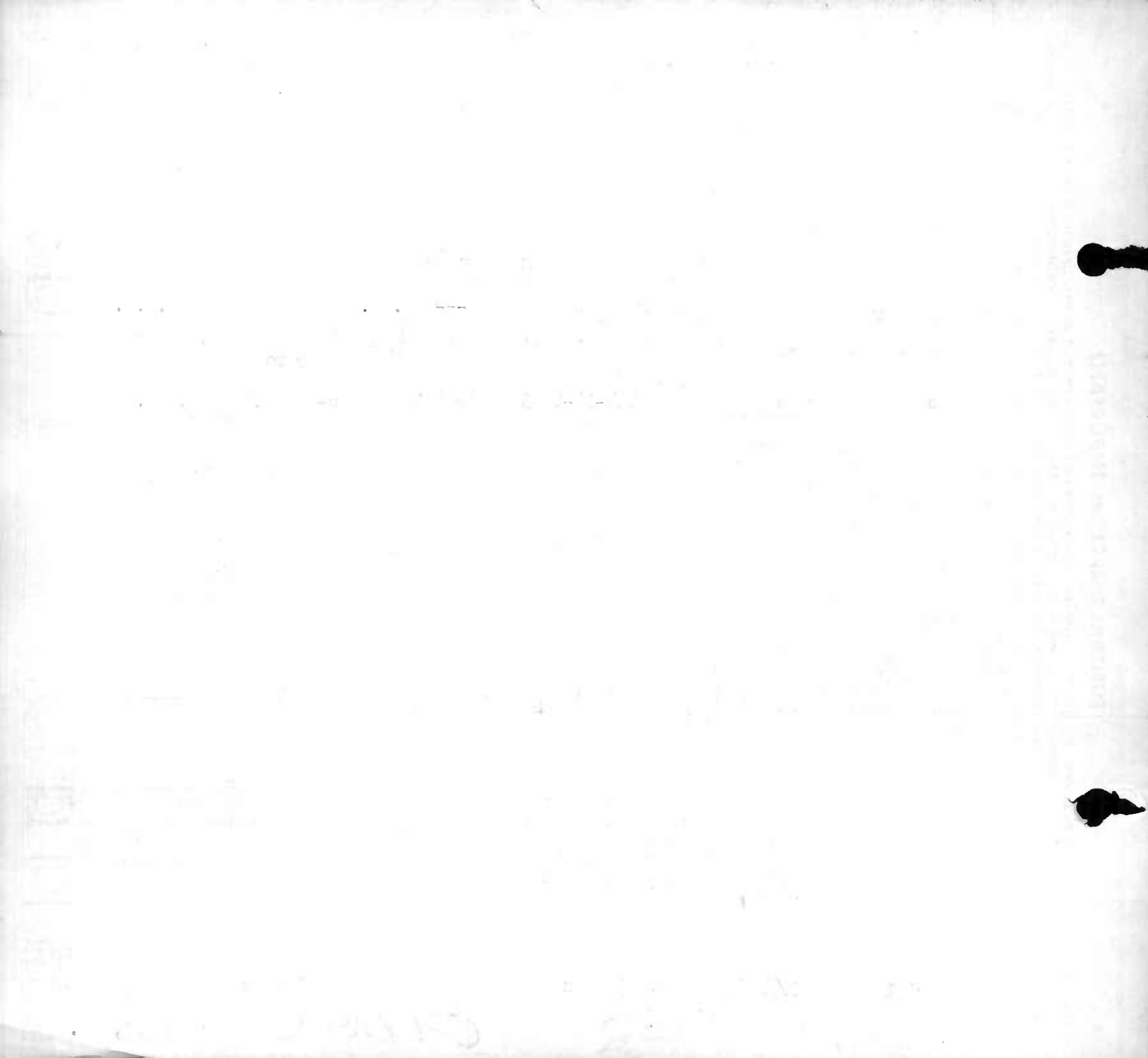
~~George H. Thompson~~ H. C. Thompson (son)
1910/12 72
1910/12 72
1910/12 72

W. J. Blackwell Group, Little, Ark.
1910/12 72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

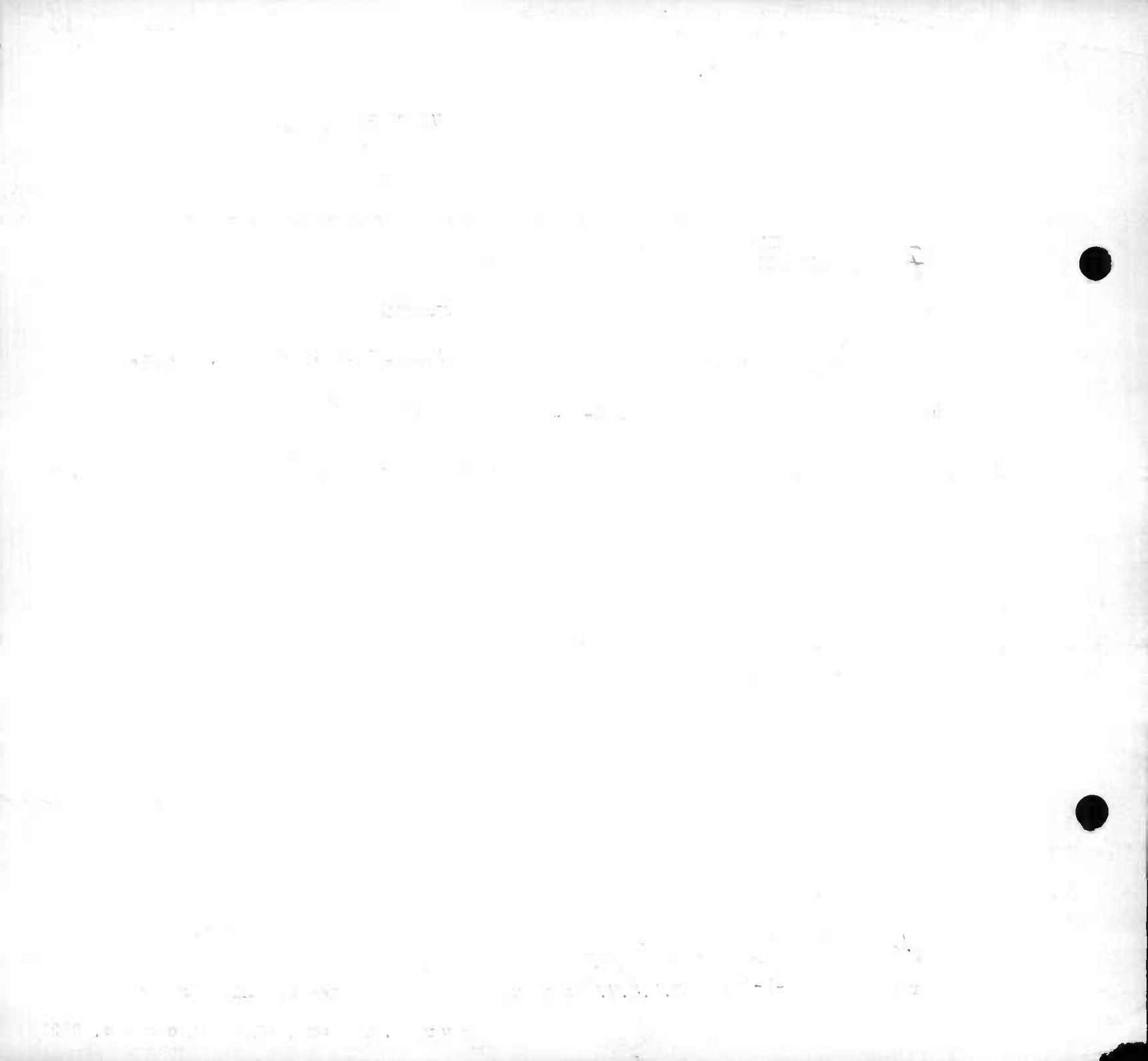
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|--|---------|--|---|--|---|--|---|--|------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| REG. NO. <u>71 2224</u> | | | | | | | | | | | |
| M-630 | | 71 2224 | | BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | |
| Robert Moorehead | | | | 2. DATE AND HOUR OF DEATH March 1, 1971 11:05 AM | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL | | | | | | A. STATE Md | | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | | B. COUNTY Baltimore | | | | | |
| 5. SEX M | | | | | | 6. RACE W | | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | 8. DATE OF BIRTH 9-16-28 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | | | | |
| 11. BIRTHPLACE (State or foreign country) W. Va. | | | | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | |
| 13. FATHER'S NAME Virgel Moorehead | | | | | | 14. MOTHER'S MAIDEN NAME Bessie Moore | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean | | | | | | 16. SOCIAL SECURITY NO. 214-34-2063 | | | | | |
| 17. INFORMANT Virginia Pritts- Bloomington, Md. | | | | | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION 12/28/71 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Malignant tumors | | | | 20A. AUTOPSY? (Yes or No) NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/12 to 3/1 1971 that (I) (we) last saw the deceased alive on 3/1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Martin L. Epps M.D. | | | | | | | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | 23D. ADDRESS | |
| DEGREE | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 3/5/71 | | | | 24C. NAME of CEMETERY or CREMATORY Bloomington | | | |
| 24D. LOCATION Bloomington | | | | (City, town, or county) | | | | (State) Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | | 25B. NAME OF REGISTRAR John E. Taylor | | | | 25C. FUNERAL DIRECTOR E. J. Neal | | | |
| ADDRESS Westernport, Md. | | | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. | |
|--|-------------------------|---|------------------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) <i>Margaret N. Ritchey</i> | | 2. DATE AND HOUR OF DEATH <i>3-4-71 7:30 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hosp of Baltimore M.D.</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <i>VIRGINIA</i> | |
| | | C. CITY OR TOWN <i>Reston</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <i>11681 Charles Oak Ct.</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>10-4-16</i> | 9. AGE (In years last birthday) <i>54 yo</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Book Keeper.</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>-</i> | | 11. BIRTHPLACE (State or foreign country) <i>OKLAHOMA U.S.A.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>J.C. Ferguson</i> | | 14. MOTHER'S MAIDEN NAME <i>Ethel M. Fagen</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>511-05-7844</i> | | 17. INFORMANT <i>Husband</i> | |
| | | | | ADDRESS <i>Same</i> | |
| 18. <i>153101</i> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial failure</i> | | | |
| <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | (B) <i>Chronic Pulmonary embolism.</i> | | | |
| | | (C) <i>-</i> | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>1-27-71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholelithiasis</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-22</i> 19 <i>71</i> to <i>3-4</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on _____ 19 _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>S. Bencharil</i> | | DEGREE | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <i>SARDA BENCHARIL</i> | | DEGREE | | 23D. ADDRESS <i>Sinai Hosp. of Baltimore</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-8-1971</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>I.O.O.F. Cemetery</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <i>Watonga, OK Oklahoma</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1971</i> | | 25B. NAME OF REGISTRAR <i>2222</i> | | 25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i> | |
| | | | | ADDRESS <i>4107 Wilkens Ave. 21229</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| F-655 71 2226 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2226 | |
|--|-------------------------|---|--------------------------------------|--|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) EHRMAN, MR. ALFRED J. | | 2. DATE AND HOUR OF DEATH MARCH 3 1971 11 05 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY 2854 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 9 N. TREMONT ROAD | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/12/1902 | 9. AGE (In years last birthday) 68 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME JOHN EHRMAN | | 14. MOTHER'S MAIDEN NAME STOCK, ELIZABETH | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-07-1611 | | 17. INFORMANT Mrs. Yvonne J. Ehrman, 9 N. Tremont Rd. 21229 Hospital Chart | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 710914-1621 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pulmonary edema (acute) Antecedent Causes C.H.F. followed by Myocardial Infarction (acute) ASCD Arteriosclerosis, Cardiac Vascular Disease CO. of the lung | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs. hrs. days | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none | | 20A. AUTOPSY? (Yes or No) X | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>9-1-71</u> to <u>3-3-71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>9-3-71</u> and that (in my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ferdous Kazemi | | | | 23B. DATE SIGNED 3-3-71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. FERDOUS KAZEMI | | | | 23D. ADDRESS BON SECOURS HOSPITAL, BALTIMORE MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-1971 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | |
| 25B. NAME OF REGISTRAR John E. Hubbard | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|--|---|--|---|--|
| M-210 | | 71 2227 | | 71 2227 | |
| 1. NAME OF DECEASED (Type or Print) JAMES M^C ABEE | | 2. DATE AND HOUR OF DEATH 3-5-71 12²⁰ P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1547 | | | |
| 5. SEX M. | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAINER | | 10B. KIND OF BUSINESS OR INDUSTRY RACE HORSE | | 8. DATE OF BIRTH 1-1-86 | |
| 13. FATHER'S NAME JAMES WESLEY M^C ABEE | | 14. MOTHER'S MAIDEN NAME EMMA COLE | | 9. AGE (In years last birthday) 85 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-03-2960 | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 17. INFORMANT (Name) Mr. William H. M^C ABEE | | 17. ADDRESS 112 Cheltenham Road NEWARK, DELAWARE 19711 | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 18. 485 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) SEPTICAEMIA. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BRONCHO PNEUMONIA. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHO PNEUMONIA. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Asotaemia. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 3-4-1971 to 3-5-1971 that (I) (we) last saw the deceased alive on 3-5-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Amaya Memon | | | | 23B. DATE SIGNED 3/6/71 | |
| 23C. PHYSICIAN'S NAME (Type) ABDUL MAJID MEMON | | 23D. ADDRESS Lutheran Hospital of Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar. 8, 1971 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel Meth. Ch. Cem. | |
| 24D. LOCATION Emmorton, Harford Co., Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Zuber, M.D. | | 25C. FUNERAL DIRECTOR Joseph William Foster | | | |
| 25D. ADDRESS W. Broadway & Williams St. Del Air, Maryland 21014 | | | | | |

Coded to NHAS NO other

Address could be obtained

31

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X REG. NO. | |
|---|------------------|--|-----------------------------|---|---|
| BIRTH NO. | | 71 2228 | | 71 2228 | |
| 1. NAME OF DECEASED (Type or Print) Mary Josephine Sharp | | 2. DATE AND HOUR OF DEATH 3/3/71 | | 8:35 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland, B. COUNTY Anne Arundel C. CITY OR TOWN Glen Burnie D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 220 Oaklane S. W. 21061 | | | |
| 5. SEX female | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-28-21 | 9. AGE (in years last birthday) 50 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY General Refractories | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Gerard Aiken | | | |
| 14. MOTHER'S MAIDEN NAME Mary J. McKenna | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT 4940 Eastern Avenue BCH-Records Baltimore, Maryland 21224 | | | |
| 18. 4/2/41 + 2509 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Brain stem CVA DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mos. at least 6 mos. ? | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 2/24 to 3/3 1971 that (we) lost saw the deceased alive on 3/3 1971 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE Russell Harris MD. | | | | 23B. DATE SIGNED 3/3/71 | |
| 23C. PHYSICIAN'S NAME (Type) Russell Harris MD. | | 23D. ADDRESS 4940 Eastern Avenue BCH- Baltimore, Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8 Mar. 71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION Baltimore | | 24E. (City, town, or county) (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR John E. Taber, R.D. | | 25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md. | |

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11/11/11



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

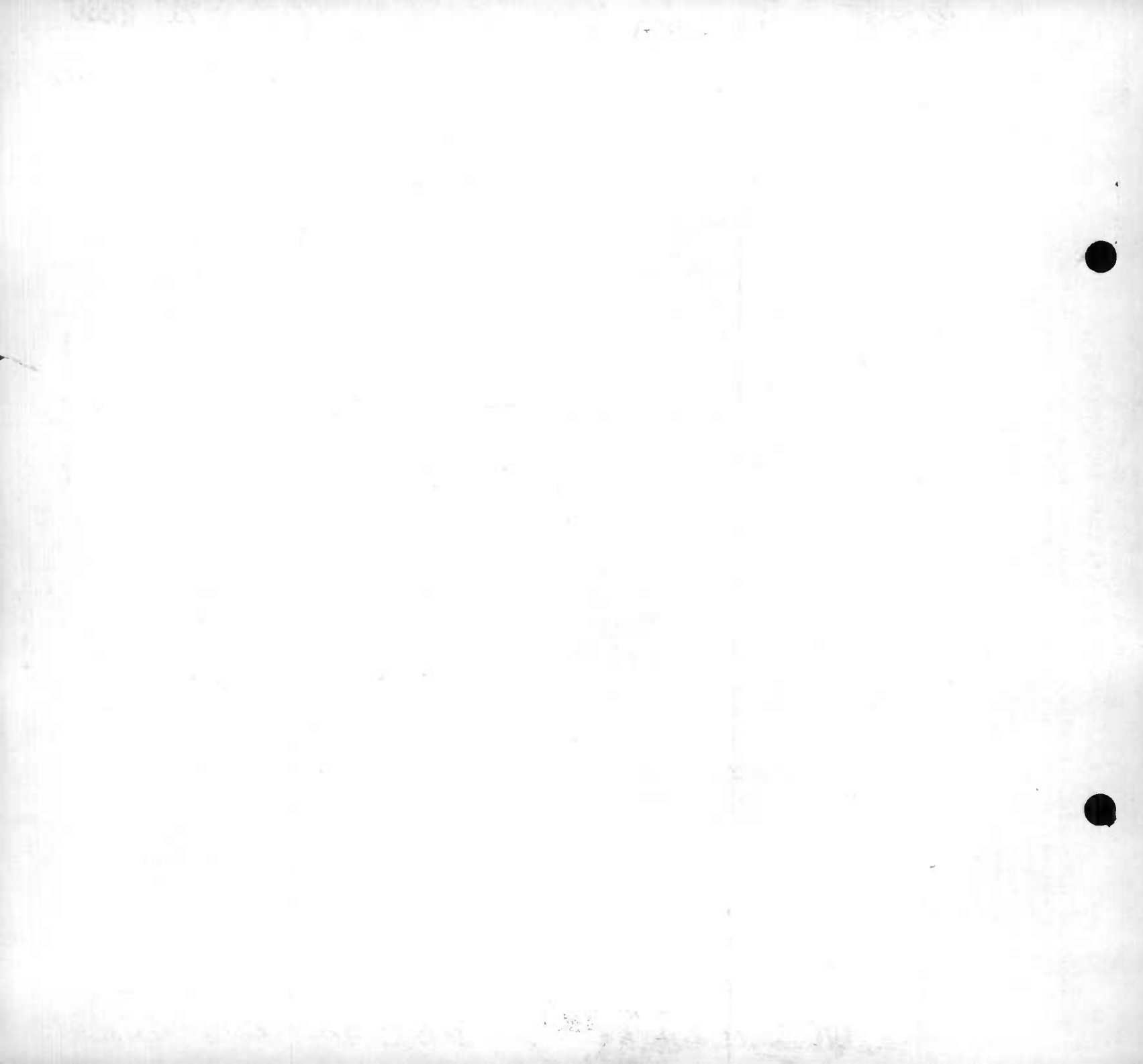
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2238 | |
|---|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Charles Peyton Fawcett | | 2. DATE AND HOUR OF DEATH March 3, 1971 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1202 Cox St. | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 1348 | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 12/14/04 | | 9. AGE (In years last birthday) 66 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME William A. Fawcett | | 14. MOTHER'S MAIDEN NAME Bertha Peyton | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-14-2387 | | 17. INFORMANT Lillian G. Fawcett-1202 Cox St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 437.0 II DISEASE OR CONDITION DIRECTLY LEADING TO DEATH cerebrovascular accident | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) hypertension DUE TO, OR AS A CONSEQUENCE OF: several years | | | |
| | | (C) cerebro-vascular arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: several yrs. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 1962 19 to March 3 1971, that (I) (we) last saw the deceased alive on Feb. 10 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. Ellsworth Cook M.D. | | | | 23B. DATE SIGNED 3-5-71 | |
| 23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK M.D. | | 23D. ADDRESS 2431 Maryland Ave. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/71 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION Balto. | | 24E. (City, town, or county) (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Donovan Funeral Home-3818 Roland Ave. | |
| 25D. ADDRESS 2222 0 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

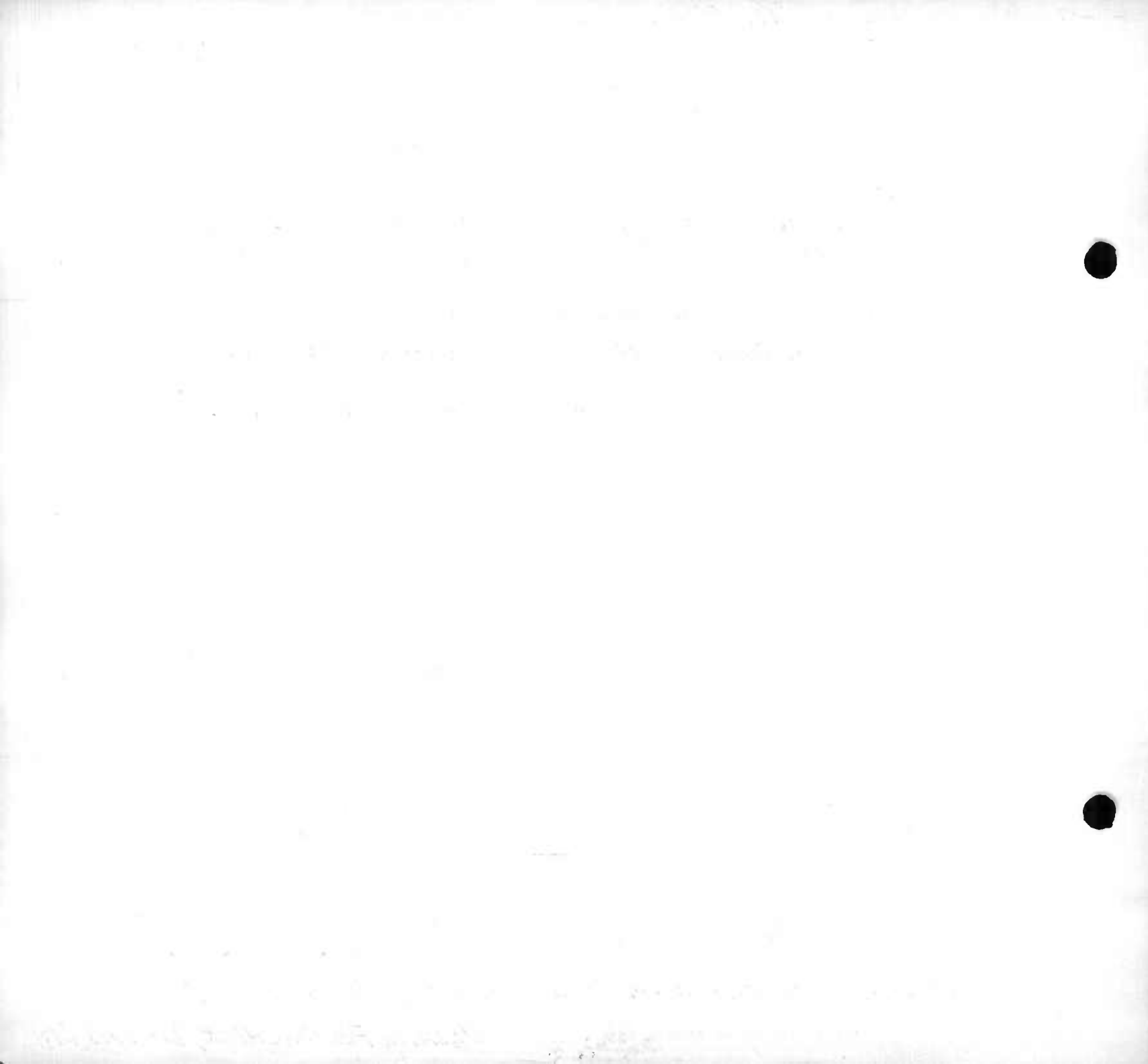
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 71 2230 | |
|--|------------------|--|---|--|---|
| W-425 BIRTH NO. | | 71 2230 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Ephriam Wilson</i> | | | 2. DATE AND HOUR OF DEATH <i>March 3, 1971 2:25 P.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>48 Maryland General Hosp</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>401</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore City</i> D. STREET ADDRESS (If rural, give location) <i>305 W. Franklin St.</i> | | |
| 5. SEX <i>♂ M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED <i>WIDOWED, DIVORCED (specify)</i> | 8. DATE OF BIRTH <i>1-16-86</i> | 9. AGE (In years last birthday) <i>85</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Owner</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Trailer Park</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>UNKNOWN</i> | | | 14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>214-22-3444A</i> | | 17. INFORMANT <i>Ethel Lee Kralick 1903 Sherwood Rd</i> | |
| 18. <i>E8871X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) <i>Brucnopneumonia, bilateral</i> DUE TO (B) <i>Fracture of left hip</i> DUE TO (C) <i>1 1/2 mth</i> | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Congress Hotel</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>same 4-01</i> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>1/26/71</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>d. fell and fx hip</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>A. Segueira</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) <i>Alexandro Segueira</i> | | | 23D. ADDRESS <i>M.D.</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>3/6/71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Cemetery</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <i>Porsey, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1971</i> | | 25B. NAME OF REGISTRAR <i>2230.4</i> | | 25C. FUNERAL DIRECTOR <i>Andreas 3061328 Sulphur Sp. Rd.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

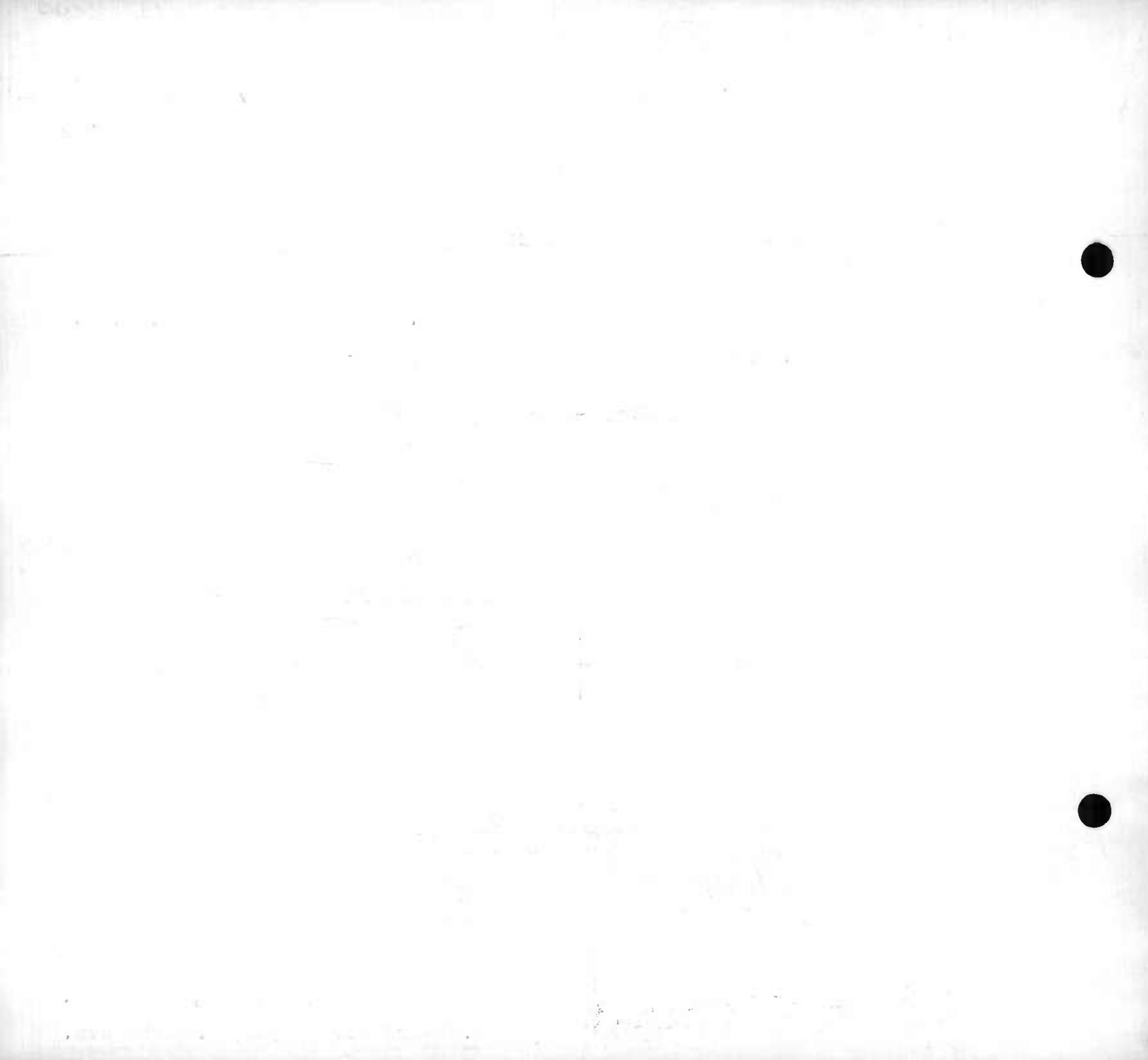
| | | | | | | | |
|--|--|--|--|--|--|---|--|
| D-255 | | 71 2231 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2231 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) GEORGE O. DIEKMANN | | | | 2. DATE AND HOUR OF DEATH MARCH 3 1971 6:03 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland, Baltimore B. COUNTY 5300 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 11-19-1984 9. AGE (In years last birthday) 86 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY BUILDING | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME John DIEKMANN | | | | 14. MOTHER'S MAIDEN NAME Wilhelmina JAEFFER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213-34-4359 | | | |
| 17. INFORMANT 4940 Eastern Ave. ADDRESS BCH-Records Baltimore, Md. 21224 | | | | | | | |
| 18. 410.91 CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction | | | | 10 Hours | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Atherosclerotic Cardiovascular Disease | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) - | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | | | |
| 22. I certify that (this hospital) attended the deceased from March 3 1971 to March 3 1971 that (we) last saw the deceased alive on March 3 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE James K. Young M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED March 3rd 1971 | |
| 23C. PHYSICIAN'S NAME (Type) JAMES K-H. YOUNG M.D. | | | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Balto., Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE MARCH 71 | | 24C. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE CEMETERY | | 24D. LOCATION (City, town, or county) (State) HOWARD CO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Public E. Taylor | | 25C. FUNERAL DIRECTOR CHURCH FUNERAL HOME, DUNDALK, MD. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. |
|--|---|---|--|---|
| 1. NAME OF DECEASED (Type or Print) LENA F. DARR | | 2. DATE AND HOUR OF DEATH March 4th 1971 11:20 am | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION HARBOR VIEW NURSING HOME | | A. STATE MARYLAND B. COUNTY Frederick C. CITY OR TOWN Brunswick D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 21 EAST D STREET | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/23/86 | 9. AGE (in years, last birthday) 84 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va. |
| 13. FATHER'S NAME John P. Darr | | 14. MOTHER'S MAIDEN NAME Anna Wilt | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-30-9616 | | 17. INFORMANT Chart. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) ASCVD - Chronic DUE TO, OR AS A CONSEQUENCE OF: brain damage (C) Gen - osteoarthritis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour several years |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work At Work | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-20 19 70 to 3-4 19 71 that (I) (we) last saw the deceased alive on February 8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE E. H. Weiss | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-4-71 |
| 23C. PHYSICIAN'S NAME (Type) E. H. Weiss | | 23D. ADDRESS 615 Hammonds Lane - 21225 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE 3-6-1971 | 24C. NAME OF CEMETERY OR CREMATORY Union | 24D. LOCATION Lovettsville, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | 25B. NAME OF REGISTRAR Robert E. J. ... | 25C. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave. | | |



G-125

71 2233 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2233

BIRTH NO.

REG. NO.

| | | | |
|--|-------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) EDWIN OWEN GIBSON | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 4, 1971 Hour 7:25 A. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year March 4, 1971 Hour 7:25 A. M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY BALTIMORE | | C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 5300 | |
| 6. SEX Male | 7. RACE White | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | E. STREET AND NUMBER 5524 Link Avenue |
| 9. DATE OF BIRTH 4/11/93 | | 10. AGE (In years lost birthday) 77 | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME UNKNOWN | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleric | | 14B. KIND OF BUSINESS OR INDUSTRY Warehouse | |
| 15. MOTHER'S MAIDEN NAME Unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 212-05-2085 | | 18. INFORMANT Mary Davidson 811 Janice Dr. Annapolis | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) No | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 4, 1971 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Louisa Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert J. [illegible] | |
| 25C. FUNERAL DIRECTOR Andrew Kuc 1328 Sulphur Sp Rd | | ADDRESS | |

ALCANTARA

VALLEY PARK

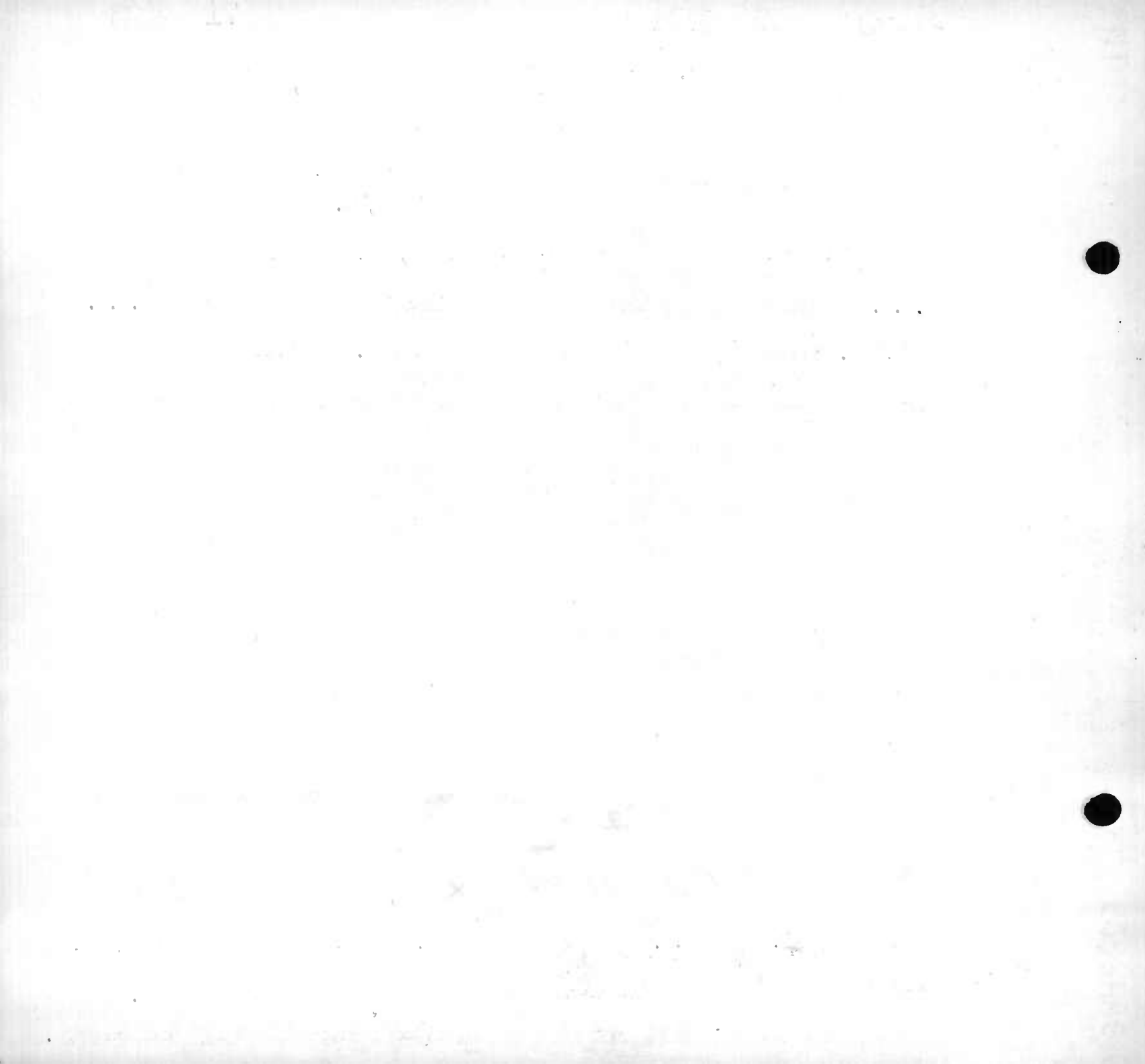
VALLEY PARK

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

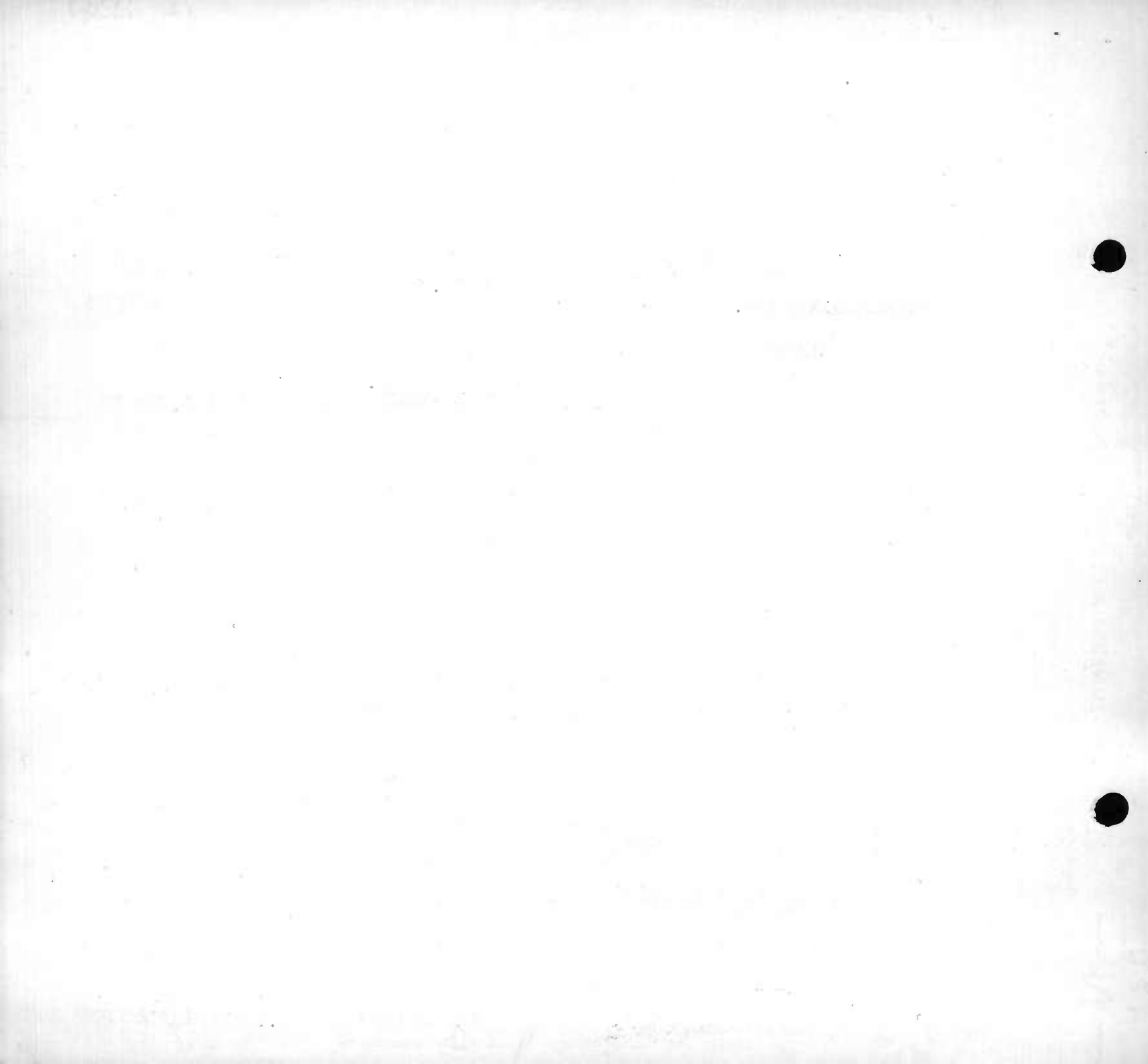
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2234 | REG. NO. 71 2234 |
|--|-------------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. H-560 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Theodore W. Hammer | | | 2. DATE AND HOUR OF DEATH March 3, 1971 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 4115 Audrey Avenue | | | A. STATE Maryland B. COUNTY 2544 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN 4115 Audrey Avenue | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER Baltimore, d. | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 16, 1886 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. R.R. Supervisor | | 10B. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Philip C. Hammer | | | |
| 14. MOTHER'S MAIDEN NAME Mary W. Garrison | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT ADDRESS Eula Lee Hammer 4115 Audrey Avenue | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 41231 | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE CORONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (A) | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 30 19 70 to March 19 71 , that (I) (we) last saw the deceased alive on 3-4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Mario E. Comas M.D. | | | | 23B. DATE SIGNED 3/5/71 | |
| 23C. PHYSICIAN'S NAME (Type) MARIO E. COMAS M.D. | | | | 23D. ADDRESS 203 E. PATAPSCO AVENUE BALTIMORE, Md. 21225 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/71 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery | |
| 24D. LOCATION Glen Burnie Md. | | 24E. IF CITY, TOWN, OR COUNTY (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS McCutty Funeral Home 237 Patapsco Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|--|--|--|--|--|
| G-425 71 2235 | | 71 2235 | | | |
| BIRTH NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | XXXXX JACK S. GLASSMAN | | 3/2/71 1823 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| Maryland General Hospital | | MD CITY | | 2740 | |
| 48 | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER | |
| 3303 Taney Rd. | | 2125 | | F. AGE (In years lost birthday) | |
| 5. SEX | | 6. RACE | | 8. DATE OF BIRTH | |
| Male | | White | | 12-07-16 | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years lost birthday) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| XXXXXXXXXX PROP. | | Printing | | BALTO. Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| RUBIN GLASSMAN | | REBECCA FLOAM | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| XXXXXXXXXX NO | | 215-09-6513 | | MRS. RHEDA GLASSMAN | |
| 18. 41231 | | CAUSE OF DEATH | | ADDRESS | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | ARTEROSCLEROTIC HEART DISEASE | | 3303 TANNEY ROAD, #21215 | |
| (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 19A. DATE OF OPERATION | |
| 21. I certify that (I) (this hospital) attended the deceased from 2123 19 71 to 312 19 71, that (I) (we) last saw the deceased alive on 36 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | |
| 21F. HOW DID INJURY OCCUR? | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21G. DATE SIGNED | |
| 22. SIGNATURE | | 23. PHYSICIANS NAME (Type) | | 23D. ADDRESS | |
| George C. Samaras MD | | GEORGE C. SAMARAS MD | | 45 Bayside Drive MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 3-3-71 | | BNAI ISRAEL | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 8, 1971 | | Robert E. Taylor | | SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |



| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 6. SEX | | 7. RACE | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. DATE OF BIRTH | | 10. AGE (In years last birthday) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT | | 19. CAUSE OF DEATH | | 20. DATE OF OPERATION | | 21. AUTOPSY? (Yes or No) | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |
|--|--|--|--|-------------------------|--|--|--|---|--|----------|--|---------|--|---|--|--|--|----------------------------------|--|---|--|------------------------------|--|-------------------|--|---|--|-----------------------------------|--|--------------------------|--|---|--|-------------------------|--|--|--|--------------------|--|-----------------------|--|---|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|------------------------------------|--|---|--|---------------------------------|--|--|--|-----------------------|--|--------------|--|
| HERBERT Sidney Cohen | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year | | 3 1 71 | | 4000 Glengyle Ave., APT. E | | Maryland | | male | | white | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 00 57 58 | | BALTIMORE, MARYLAND | | USA | | NAMI COHEN | | DELIVERY | | RETAIL | | LENA ? | | NO | | 579-03-1754 | | MRS. NAOMI COHEN, 4000 GLENGYLE AVE., APT. E | | E950X | | no | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | home | | 4000 Glengyle Ave. 2720 | | 3 1 71 ? p.m. | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | shot self | | I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner | | BURIAL | | 3-3-71 | | LIBERTY PARK (PROGRESSIVE SICK BENEFIT & RELIEF ASSN) | | RANDALLSTOWN, MARYLAND | | MAR 8 1971 | | VS 151-REV. 1/7/68 | | SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | | |

VAULTS OPENED

ADDITIONAL

FOR CONT

RECEIVED

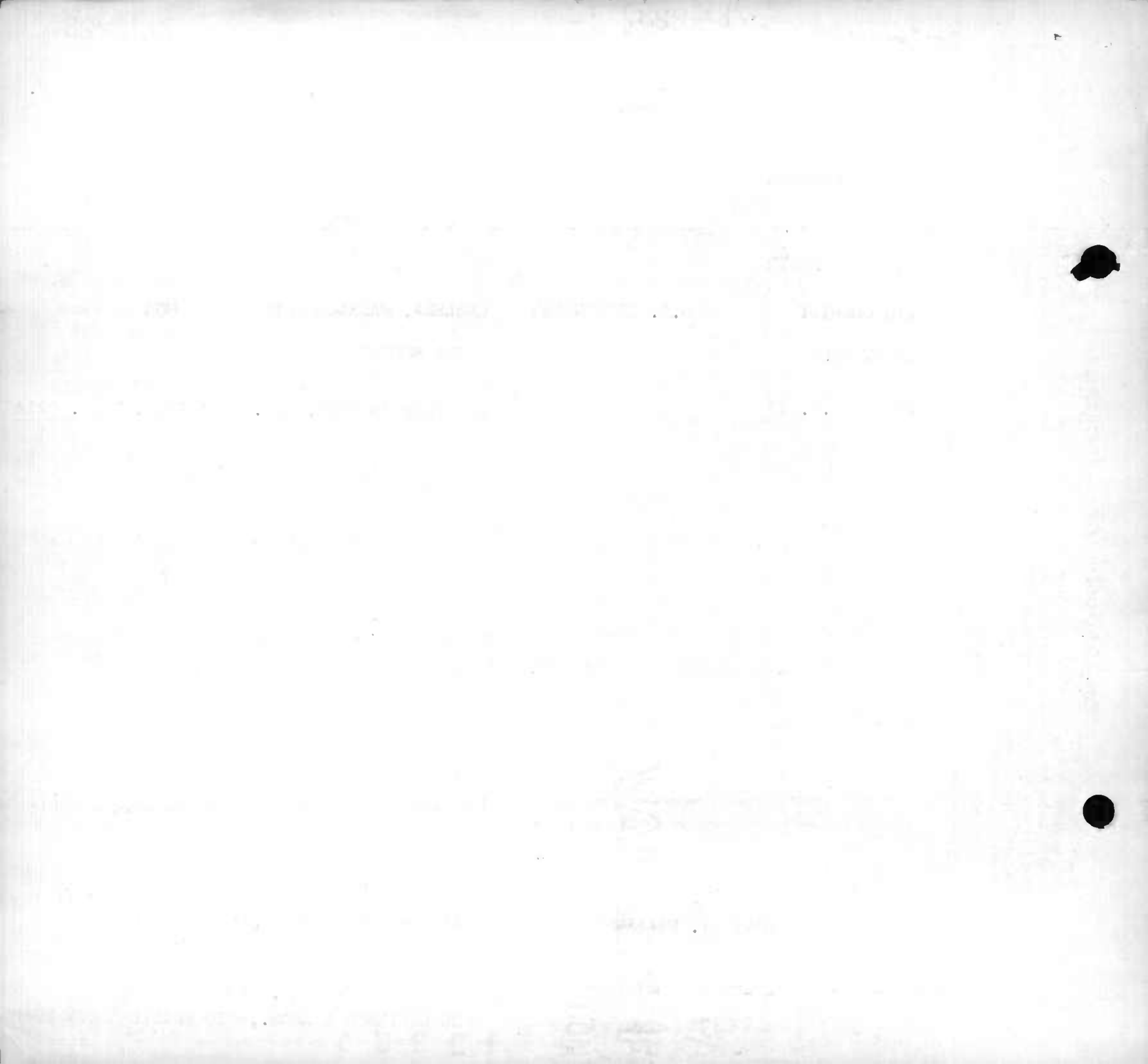
INITIAL

FOR EXAMINATION & RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2237 | |
|--|--------------------------------|---|---|--|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) | | MORRIS GREEN | | 2. DATE AND HOUR OF DEATH MARCH 3, 1971 5 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 2720 C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3823 MENLO DRIVE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUGUST 12, 1910 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BIO CHEMIST | | 10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT | | 11. BIRTHPLACE (State or foreign country) CHELSEA, MASSACHUSETTS | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME HARRY GEEN | | | |
| 14. MOTHER'S MAIDEN NAME IDA SCHNEIDERMAN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT 1615 BEACON STREET TORF FUNERAL HOME, INC. BROOKLINE, MASS. 02146 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 + 250.9 | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Myocardial Infarction</i> minutes DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arteriosclerosis</i> years DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Dilated Myocardium</i> years | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | II | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>March 3, 1969</i> to <i>March 3, 1971</i> , that (I) (we) last saw the deceased alive on <i>Feb 19, 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>David I. Miller</i> | | | | 23B. DATE SIGNED <i>March 4, 1971</i> | |
| 23C. PHYSICIAN'S NAME (Type) DAVID I. MILLER | | | | 23D. ADDRESS 9115 REISTERSTOWN ROAD <i>Dwight Mills, Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL-BURIAL | | 24B. DATE 3-7-71 | | 24C. NAME OF CEMETERY or CREMATORY ONIKCHTY | |
| 24D. LOCATION (City, town, or county) (State) MELROSE, MASSACHUSETTS | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Safford</i> | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2238</u> | |
|--|-------------------------|---|-------------------------------------|---|---|
| <div style="display: flex; justify-content: space-between;"> T-400 <u>71 2238</u> CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>TOLL, SAMUEL</u> | | 2. DATE AND HOUR OF DEATH <u>8 MARCH 2, 1971</u> <u>900 AM</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> <u>44</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <u>MD.</u> | |
| | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>3506 ROSEKEMP AVE.</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-24-00</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REXXXXX BUYER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>DEPARTMENT STORE</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>ELLIS XXXX TOLCHINSKY</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>JENNIE XXXXXX UNKNOWN</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>XXXXXX</u> NO | | | |
| 16. SOCIAL SECURITY NO. <u>216-03-3365A</u> | | 17. INFORMANT <u>MRS. SOPHIA TOLL</u> ADDRESS <u>SAME AS ABOVE</u> | | | |
| 18. <u>728X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>MYOCARDIAL INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>?</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Feb. 27</u> 19 <u>71</u> to <u>March 2</u> 19 <u>71</u> that (I) <u>(we)</u> lost saw the deceased alive on <u>March 2</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | |
| 23A. SIGNATURE <u>Tobru</u> <u>abc</u> | | 23B. DATE SIGNED <u>March 2, 71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Tobru</u> <u>DHE</u> | |
| 23D. ADDRESS <u>Union Memorial Hospital</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | |
| 24B. DATE <u>3-4-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>CHZUK AMUNO (ARLINGTON)</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Faber</u> | | 25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2239 | |
|--|--|--|--|--|--|
| BIRTH NO. K-480 | | 71 2239 | | 1. NAME OF DECEASED (Type or Print) Kelly William L | |
| 2. DATE AND HOUR OF DEATH 3/1/71 1 1AM M. | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | |
| 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 2553 | | | 5. FULL NAME OF HOSPITAL OR INSTITUTION Saint Agnes Hospital 4.0 Caton & Wilkensa Aves. 21229 | | |
| 6. CITY OR TOWN Baltimore | | | 7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 8. STREET AND NUMBER 16/ 1716 Sexton Street 21230 | | | 9. SEX M | | |
| 10. DATE OF BIRTH 10/17/1900 | | | 11. AGE (In years last birthday) 70 | | |
| 12. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | | 13. CITIZEN OF WHAT COUNTRY? U.S.A | | |
| 14. FATHER'S NAME George Kelly | | | 15. MOTHER'S MAIDEN NAME Lillian McNair | | |
| 16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 17. SOCIAL SECURITY NO. Mrs. Mabel Kelly Above Address | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4.10.9 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few minute 20 Years | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 9 - 19 70 to Feb. 16 19 71 that (I) (we) last saw the deceased alive on Feb. 16, 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Nureddin Erk MD | | | | 23B. DATE SIGNED 3-3-1971 | |
| 23C. PHYSICIAN'S NAME (Type) Nureddin Erk MD | | | | 23D. ADDRESS 2436 Washington Blvd, Balt. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/4/71 | | 24C. NAME OF CEMETERY OR CREMATORY Western Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR McCutty 3300 E. Fort Avenue | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2240 | |
|--|-------------------------|--|--|---|---|
| BIRTH NO. P-200 | | 31 2240 | | | |
| 1. NAME OF DECEASED (Type or Print) CLINTON C. PUGH | | | 2. DATE AND HOUR OF DEATH 3/3/71 3:00 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GENERAL HOSP. | | | A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 727 S. POTOMAC ST. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-29-06 | 9. AGE (In years last birthday) 64 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDSEWER | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 13. FATHER'S NAME SAMUEL PUGH | | | 14. MOTHER'S MAIDEN NAME SUZIE STERLING | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK | | | 16. SOCIAL SECURITY NO. 2 15-09-7228 | | |
| 17. INFORMANT Hosp chart | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 163.1 I CAUSE OF DEATH regulation of coronary artery with recent MI (A) IMMEDIATE CAUSE Ca of the Lung E Liver metastasis DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 2/27 19 71 to 3/3 19 71 that (I) (we) last saw the deceased alive on 3/3 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Teodoro R. Carangal | | | | 23B. DATE SIGNED 3/3/71 | |
| 23C. PHYSICIAN'S NAME (Type) TEODORO R. CARANGAL | | | | 23D. ADDRESS NORTH CHARLES GENERAL HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/8/71 | | 24C. NAME of CEMETERY or CREMATORY OAK LAWN | |
| 24D. LOCATION BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Carroll Funeral Home 300 Trace Ave. | | | |

#2 #

CERTIFICATE OF DEATH

| | | | | | |
|--|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO. 0-563 71 2241 | | 1. NAME OF DECEASED (Type or Print) William Conrad | | 2. DATE AND HOUR OF DEATH March 2, 1971 7:52 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | 4. RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland & COUNTY Baltimore C. CITY OR TOWN BAULEYS AVENUE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 185 Long Beach Road 21220 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-21-22 | 9. AGE (In years last birthday) 48 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER | | 10B. KIND OF BUSINESS OR INDUSTRY TRUCKING | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George CONRAD | | | |
| 14. MOTHER'S MAIDEN NAME Pauline KING | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK | |
| 16. SOCIAL SECURITY NO. 218-18-6174 | | 17. INFORMANT 4940 Eastern Avenue ADDRESS BCH: Records Baltimore, Maryland 21224 | | | |
| 18. 291.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE coma, etiology? DUE TO, OR AS A CONSEQUENCE OF: 7 days | | | | | |
| (B) ? cirrhosis, hepatic encephalopathy DUE TO, OR AS A CONSEQUENCE OF: 7 days | | | | | |
| (C) ? DT's, ? anoxic insult DUE TO, OR AS A CONSEQUENCE OF: 7 days | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 3/1/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED respiratory failure | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If in Baltimore City, give exact location) <input type="checkbox"/> NO | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/20 19 71 to 3/2 19 71 that (I) (we) last saw the deceased alive on 3/2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE Henry Herrera | | 23B. DATE SIGNED 3/2/71 | | 23C. PHYSICIAN'S NAME (Type) Henry Herrera | |
| 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | |
| 24B. DATE 3/5/71 | | 24C. NAME OF CEMETERY or CREMATORY HOLLY HILL | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR 3002 Maple Ave | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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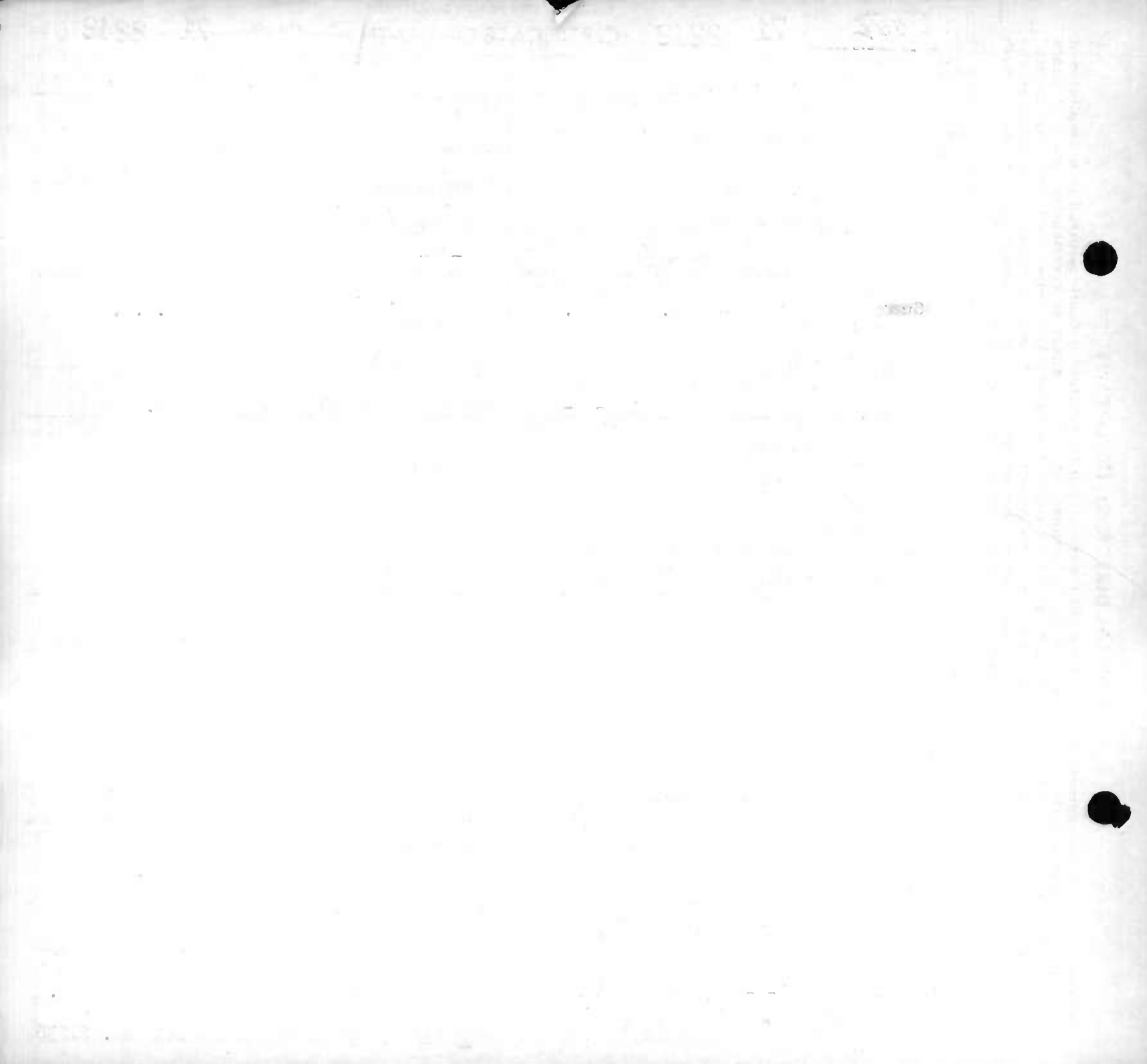
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | CERTIFICATE OF DEATH | | REG. NO. 71 2242 | |
|--|--|--|--|--|--|---|--|---|--|
| BIRTH NO. <u>S-246</u> | | 71 2242 | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Thelma Schuessler</u> | | | | 2. DATE AND HOUR OF DEATH <u>March 2, 1971</u> <u>7:11 PM</u> M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>111 McCormick Ave</u> | | | | | |
| 5. SEX <u>F</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-28-97</u> | | 9. AGE (In years last birthday) <u>73</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Education</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Andrew Walz</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Minnia Solveck</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>214-40-4544</u> | | 17. INFORMANT <u>Marie Magrogan</u> ADDRESS <u>111 McCormick Ave. 21206</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Old & acute MI</u> | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Extensive ASCVD</u> | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | | | (C) <u>Diabetes mellitus</u> | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/2/71</u> to <u>3/2/71</u> and that (I) (we) last saw the deceased alive on <u>3/2/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Pratima Bose</u> | | | | 23B. DATE SIGNED <u>3/3/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>PRATIMA BOSE</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-6-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u> | | 24D. LOCATION (City, town, or county) <u>Baltimore</u> | | (State) <u>Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Lassan Funeral Home</u> | | ADDRESS <u>7401 Belair Rd. 21236</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. <u>71 2243</u> | |
|--|--|---|--|--|--|
| 0-420 71 2243 CERTIFICATE OF DEATH | | BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Olask, Miriam</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Pleasant Manor Nursing Center</u> <u>904615 Park Heights Ave.</u> | | 2. DATE AND HOUR OF DEATH <u>3-3-71 9 45 AM</u> | | | |
| 5. SEX <u>F</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>6/5/06</u> | |
| 13. FATHER'S NAME <u>Louis</u> | | 14. MOTHER'S MAIDEN NAME <u>Hilda</u> | | 9. AGE (In years lost birthday) <u>64</u> 11. BIRTHPLACE (State or foreign country) <u>Pa</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>161-07-6617</u> | | 17. INFORMANT <u>Hosp death</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Carcinoma Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>Feb. 1971</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Laparotomy</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19 62 to 3/3 1971</u>, that (I) (we) lost saw the deceased alive on <u>3/1 19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Dr. Morton J. Ellin</u> | | | | 23B. DATE SIGNED <u>3/5/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Morton J. Ellin</u> | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/5/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Balto Hebrew</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Reisterstown Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8, 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Sylvan Louis & Son Gammon, Md</u> | | | |

3/2/8

W-160

71 2244

BALTIMORE CITY HEALTH DEPARTMENT

71 2244

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) RUDOLPH A. WEBER, Sr. | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 2, 1971 1312 hrs. M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH Sept. 5, 1907 | | 10. AGE (In years last birthday) 63 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Hugo Weber | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME Phillipinnia ? | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 212-07-6457 | | 18. INFORMANT Balto., Md. and 21229. Mrs. Mary H. Weber-4010 Colborne Rd | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/3/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/6/71 | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | |
| 25C. FUNERAL DIRECTOR 936 Edmondson Ave. Catonville, Md. 21228 | | | |

ACAPD 511 X 1000

71 2245

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2245

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Lamper

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Delaware

SUSSEX V-02

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Seaford

YES ☒ NO ☐

6. SEX

male

7. RACE

white

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

FEB 16 1923

10. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

West Manor Apts. #32

11. BIRTHPLACE (State or foreign country)

INDIANA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

REV. ORVILLE RAY LAMPER

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

GEN. ENGINEER

14B. KIND OF BUSINESS OR INDUSTRY

WHITE CAP CO.

15. MOTHER'S MAIDEN NAME

HAZEL HUNNAMAN LAMPER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES WART

17. SOCIAL
SECURITY NO.

349-18-7110

18. INFORMANT

KITTY MARGARET LAMPER

ADDRESS SEAFORD, DEL.

19. 4-12-71

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK m. AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

3/2/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

3/4/71

24C. NAME OF CEMETERY OR CREMATORY

ST. LUKE'S Cemetery

24D. LOCATION (City, town, or county)

Seaford

(State)

Del.

25A. DATE REC'D BY HEALTH DEPT.

MAR 8, 1971

25B. NAME OF REGISTRAR

Robert E. Seabury, M.D.

25C. FUNERAL DIRECTOR

Ralph M. Whitson

ADDRESS

Seaford, Del.

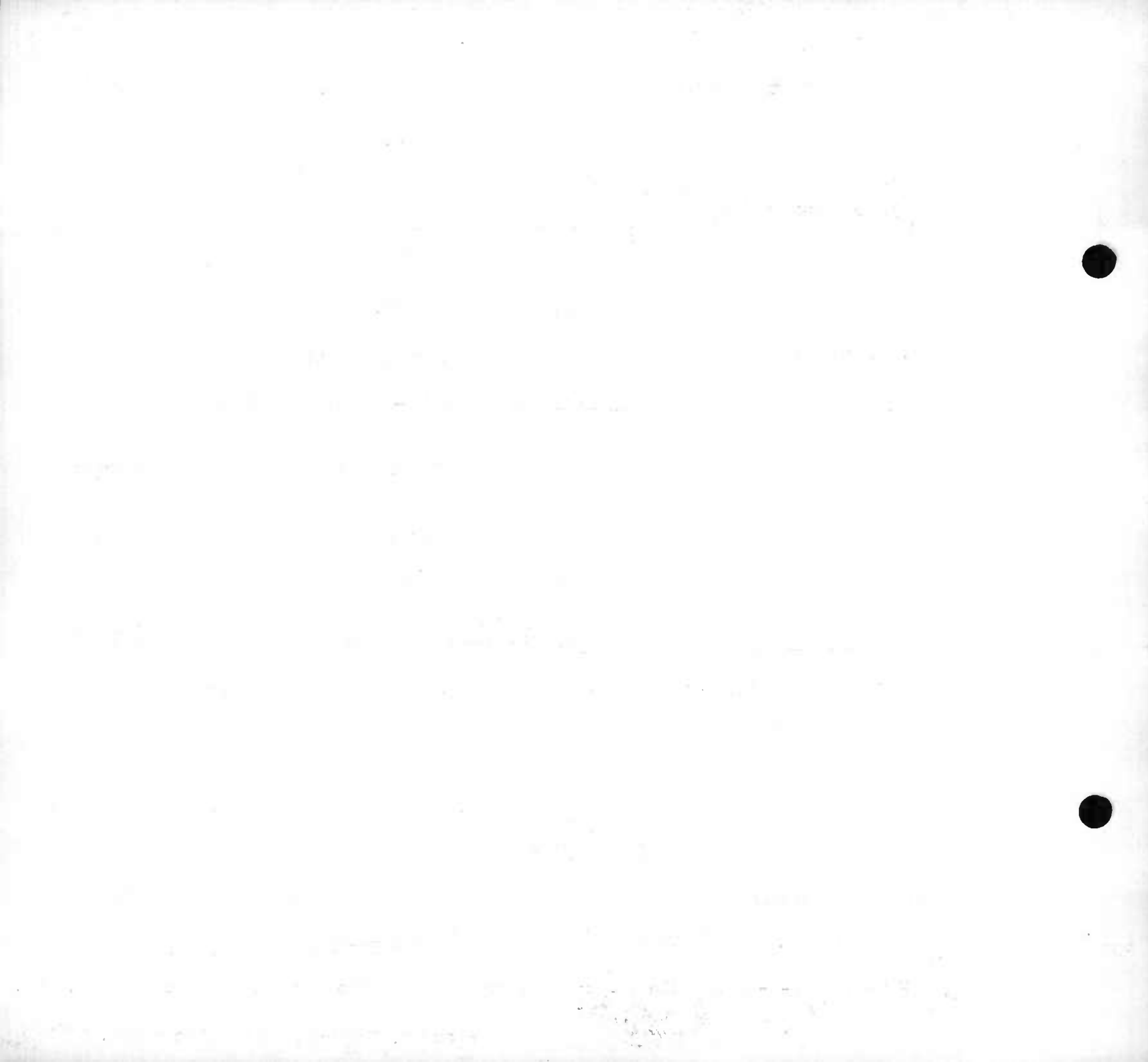
Letter from M.E.'s office

3-15-71 M.H.

Received from M.E.'s office
March 15, 1971

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|-----------------------------------|--|
| 7-520 | | 71 2246 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 71 2246 | | | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | Virgil Thomas | | | | Feb. 26, 1971 4 PM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | Va. | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | | | |
| US Public Health Service Hospital 2X 3100 Wyman Parkway | | | | Tangier Island | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. Under 1 Yr. 11. Under 24 Hrs. | |
| M | | W | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 1/1/12 | | 59 | | Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| Wiper | | | | Seafarer | | | | Va. | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | USA | | | | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| Ed. L. Thomas | | | | Cora Crockett | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| No | | | | 229-14-2964 | | | | Records- US PHS Hospital | | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | Peritonitis 9 days | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | Perforation 9 days | | | |
| ANTECEDENT CAUSES | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | Carcinoma of cecum Unknown | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | Emphysema Myocardial infarction | | | | Years 5 Years | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 2/18/71 | | Perforation of carcinoma of cecum | | yes | | yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | |
| 22. I certify that (I)/(this hospital) attended the deceased from Jan. 26 19 71 to Feb. 26 19 71 | | | | | | | | | | | |
| that (I)/(we) last saw the deceased alive on Feb. 26 19 71 and that in (my)/(our) opinion death occurred on the date and hour and from the causes stated above. (I)/(We) (did) (saw) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | 23B. DATE SIGNED | | | |
| Samuel P. Ward, M.D. | | | | | | | | 3/4/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | 23D. ADDRESS | | | |
| Samuel P. Ward (Surgeon, R) | | | | | | | | US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | | | |
| Burial | | 3-5-1971 | | Glen Haven Cemetery | | GlenBurnie, Anne Arundel Co., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | | | |
| MAR 8 1971 | | Robert E. Sabin, R.D. | | Howard H. Hubbard | | 4107 Wilkens Ave. 21229 | | | | | |



E-255

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

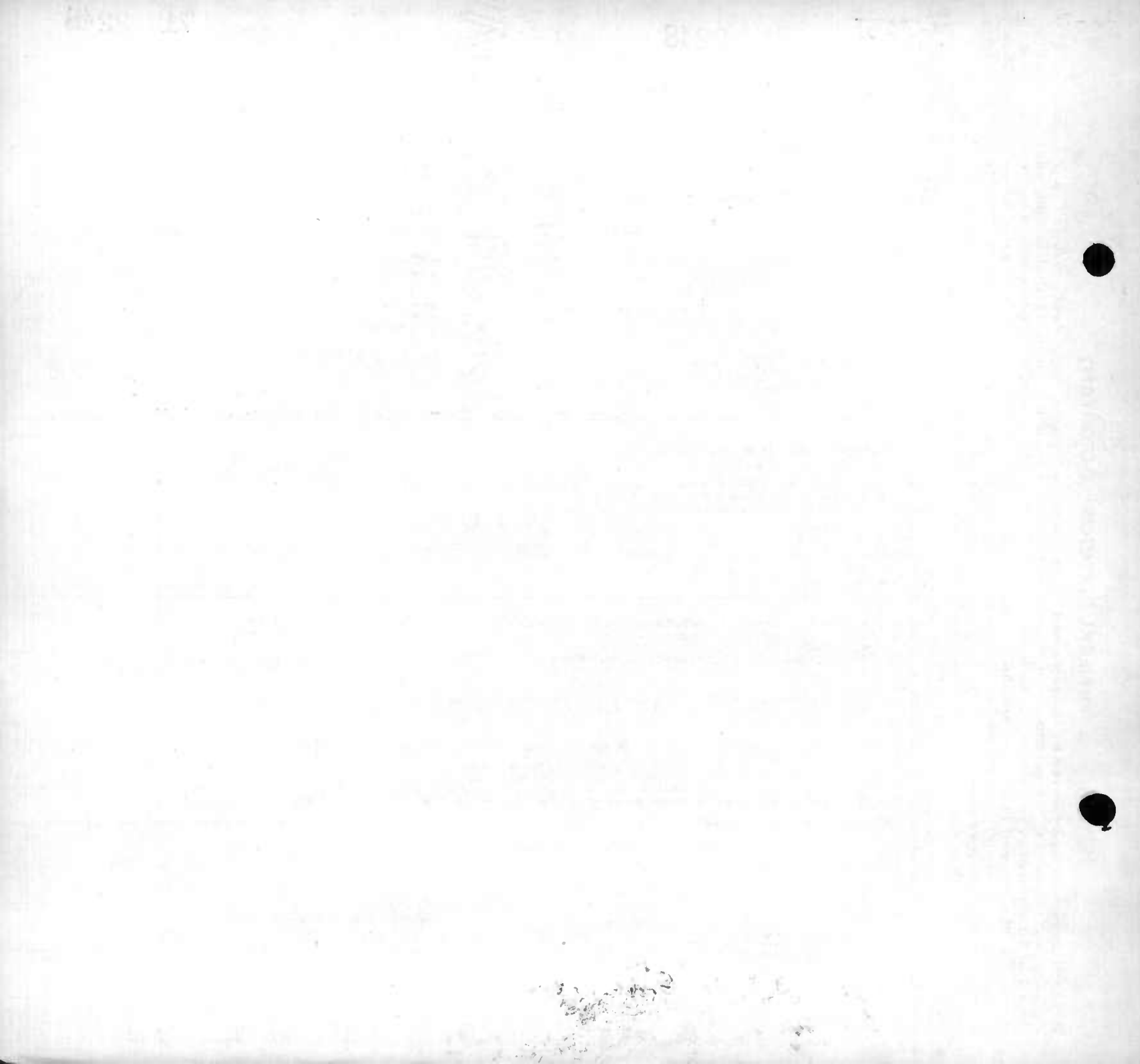
REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) PHILLIP Economides, Phillip | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 2 Day 28 Year 71 Hour 2:45 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 110 520 S. Macon St. | | 3. DATE PRONOUNCED DEAD Month 2 Day 28 Year 71 Hour 2:45 p.m. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2607 | | | |
| 6. SEX male | 7. RACE White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH 1891 | 10. AGE (In years last birthday) approx 80 | E. STREET AND NUMBER 520 S. Macon Street | |
| 11. BIRTHPLACE (State or foreign country) Greece | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Costas Economides | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurateur | |
| 14B. KIND OF BUSINESS OR INDUSTRY Restaurant | | 15. MOTHER'S MAIDEN NAME Anastasia | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 213-07-2433 | |
| 18. INFORMANT Harry Economides | | ADDRESS 726 S. Oldham St., Baltimore Md. | |
| 19. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 412.41 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (APPROX.) Month () Day () Year () Hour () | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/1/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-71 | |
| 24C. NAME of CEMETERY or CREMATORY Greek Orthodox Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Nicholas T. Matthews | |
| 25C. FUNERAL DIRECTOR 3021 Eastern Ave., Baltimore, Md. | | ADDRESS | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| P-625 | | 71 2248 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2248 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Anthony Prassinias</i> | | | | 2. DATE AND HOUR OF DEATH <i>3/1/71</i> <i>5:30</i> P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | A. STATE Maryland | | B. COUNTY <i>2605</i> | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 315 Gusryan St. 21224 007 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-22-85 | | 9. AGE (In years lost birthday) 85 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Dry Cleaning</i> | | 11. BIRTHPLACE (State or foreign country) Greece | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Gus Prassinias | | | | 14. MOTHER'S MAIDEN NAME Argiro Sikales | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. 216-32-8776-A | | 17. INFORMANT 4940 Eastern Avenue BCH-Records Baltimore, Maryland 21224 | | ADDRESS | |
| 18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Brain Syndrome 6 mos</i> <i>ASCVD</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>5 yrs.</i> (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | <i>Old MI by EKG</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that the (this hospital) attended the deceased from <i>10/14</i> 19 <i>70</i> to <i>3/1</i> 19 <i>71</i> , that he (we) last saw the deceased alive on <i>3/1</i> 19 <i>71</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. My (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Russell Harris MD</i> | | | | 23B. DATE SIGNED <i>3/1/71</i> | | 23C. PHYSICIAN'S NAME (Type) Russell Harris MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-5-71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Greek Orthodox Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1971</i> | | 25B. NAME OF REGISTRAR <i>John E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>Nicholas T. Matthews</i> | | ADDRESS <i>3021 Eastern Ave, Baltimore, Md.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| B-653 71 2249 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2249 | |
| BIRTH NO. | | M.E. CASE NO. | | CERTIFICATE OF DEATH X Registered No. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | M. | |
| Sylvester Brent | | 3/6/71 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Mid Town Nursing Home 808 St. Paul St. | | Md. D.C. 5200 | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| M. | | Colored | | M. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| Steel Miller | | | | 9/1/1912 58 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years, lost, high day) | |
| George Brent | | Cornelia Smith | | 58 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Maryland | |
| | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | U.S.A. | |
| | | | | 17. INFORMANT ADDRESS | |
| | | | | Alberta Brent - Shadyside, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 26 1971 to Mar 6 1971, that (I) (we) last saw the deceased alive on Mar 6 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| William D. Applefeld M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 3/8/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| William D. Applefeld M.D. | | 6615 Reisterstown Rd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3/9/71 | | St. Paul | |
| 24D. LOCATION (City, town, or county) | | 24E. STATE | | | |
| Shadyside D.C. | | Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 8 1971 | | Robert E. Taylor, M.D. | | William Reese - Anna, Md. | |

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8-363 71 2250 BALTIMORE CITY HEALTH DEPARTMENT 71 2250

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| WILHELMINA STREATER | | Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | | Month Day Year Hour m 3 4 1971 4:45 p.m. | | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | |
| 34 female | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | Bon Secours Hospital Maryland 2004 | |
| 9. DATE OF BIRTH 7-28-1921 | | 10. AGE (In years lost birthday) 49 | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 11. BIRTHPLACE (State or foreign country) Wadesboro, N. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | | E. STREET AND NUMBER 2102 Boyd St. | | 15. MOTHER'S MAIDEN NAME Edna Allen | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 216-22-4565 | | 18. INFORMANT James C. Streater - 2102 Boyd St. | | ADDRESS | |
| 19. 371.0 | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Fatty liver DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | PARTIAL | |
| 22D. TIME OF INJURY (APPROX.) | | 22E. INJURY OCCURRED | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 23. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 23. Part. | | | |
| ACTUAL SIGNATURE Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 3/5/71 | |
| EXAMINER'S NAME (Type) | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-9-71 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Jones, M.D. | | 25C. FUNERAL DIRECTOR Mary-Elizabeth Law | | ADDRESS 802 Madison Ave. | |

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BALTIMORE CITY HEALTH DEPARTMENT

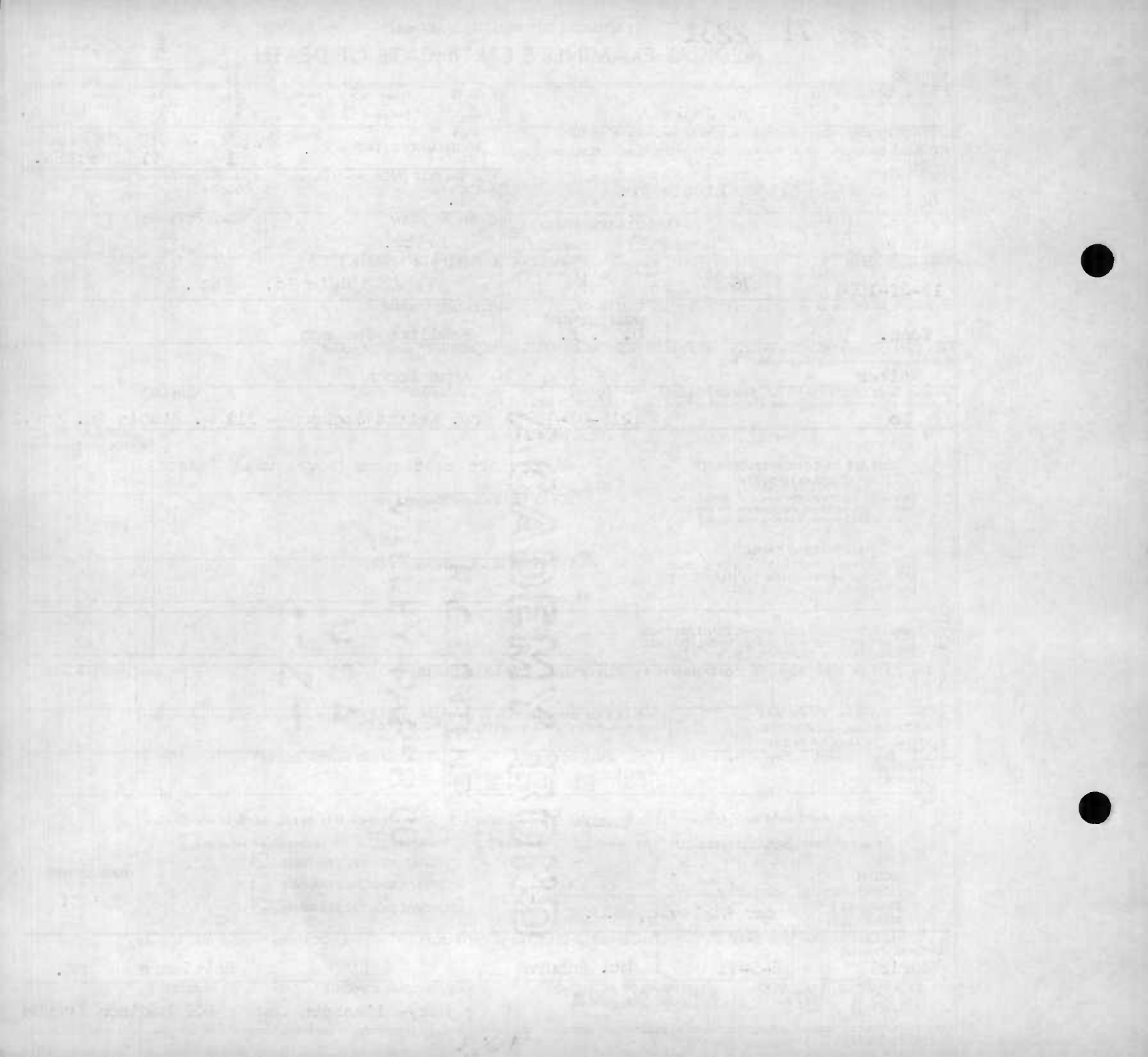
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2251

BIRTH NO.

REG. NO.

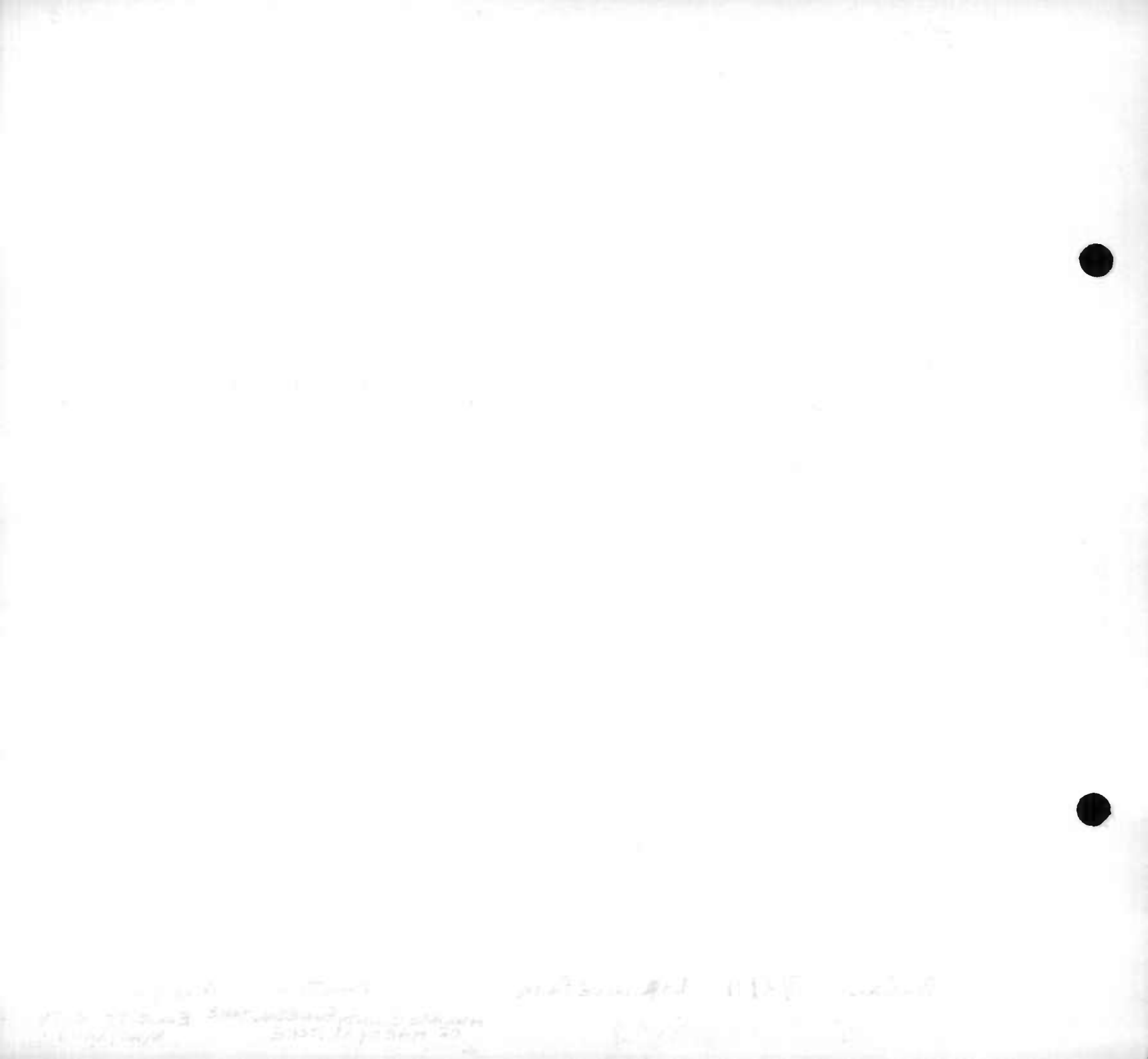
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|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) William Jackson | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 1 Year 71 Hour 9:45 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 311 W. Biddle St. | | 3. DATE PRONOUNCED DEAD Month 3 Day 1 Year 71 Hour 9:45 a.m. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 12-22-1894 | | 10. AGE (In years lost birthday) 76 | |
| 11. BIRTHPLACE (State or foreign country) Tenn. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter | | 15. MOTHER'S MAIDEN NAME Anna Bough | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 215-03-3595A | |
| 18. INFORMANT Mrs. Keitha Jackson - 311 W. Biddle St. Apt. 2 | | ADDRESS 311 W. Biddle St. - Apt. 2 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) Month () Day () Year () Hour () | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No) no | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/1/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-5-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Gabley, M.D. | |
| 25C. FUNERAL DIRECTOR Mary-Elizabeth Law | | ADDRESS 802 Madison Avenue | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|---|------------------------------------|--|--|
| 7-623 71 2252 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2252 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) HOWARD FETERMAN | | 2. DATE AND HOUR OF DEATH 1030AM on 3/5/71 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital, Baltimore, Maryland | | A. STATE MARYLAND | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | B. COUNTY Howard Co. | | | |
| C. CITY OR TOWN Ellicott City | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| E. STREET AND NUMBER 4260 Montgomery Road | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-22-97 | 9. AGE (in years last birthday) 73 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired machine | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME HENRY FETERMAN | | 14. MOTHER'S MAIDEN NAME ANNIE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I. | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS SHIRLEY KASEMEYER | |
| 18. 499X I | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE CARDIO-RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) PULMONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) PULMONARY EMPHYSEMA | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/12/1971 to 3/5/1971 that (I) (we) lost saw the deceased alive on 3/5/1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Azad Cadar | | DEGREE | | 23B. DATE SIGNED 3/5/71 | |
| 23C. PHYSICIAN'S NAME (Type) AZAD. CADAR | | DEGREE | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/8/71 | | 24C. NAME of CEMETERY or CREMATORY LORRAINE PARK | |
| 24D. LOCATION (City, town, or county) (State) BALTO. CO. MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR HOWARD COUNTY FUNERAL HOME | | ADDRESS ELICOTT CITY MARYLAND | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|--|-------------------------|---|--|--|--|---|--|---|--|
| B-260 | | 71 2253 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 71 2253 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) BAKER RICHARD WILLIAM | | | | 2. DATE AND HOUR OF DEATH MARCH 05, 1971 4:36 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>West Angler Hospital</i> | | | | | | A. STATE MARYLAND | | B. COUNTY <i>Howard CO.</i> | |
| | | | | | | C. CITY OR TOWN ELLICOTT CITY | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | E. STREET AND NUMBER 3910 HAWTHORNE ROAD 21043 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-15-20 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESEARCH DIRECTOR | | | | 10B. KIND OF BUSINESS OR INDUSTRY CLARKSVILLE, MD. W. R. GRACE | | 11. BIRTHPLACE (State or foreign country) DELAWARE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HENRY BAKER | | | | 14. MOTHER'S MAIDEN NAME DEC'D BESSIE (WINE) BAKER | | 17. INFORMANT BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW2 | | | | 16. SOCIAL SECURITY NO. 142-24-6084 | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Respiratory Failure. Metastatic C.A.</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH <i>Cancer Left Pleura (Splenetic)</i> | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION 22nd Feb: 1971 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Left Splenic Pleura</i> | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.] | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 08 1971 to MARCH 05 1971 that (I) (we) last saw the deceased alive on MARCH 05 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Patel Qureshi</i> | | | | | | 23B. DATE SIGNED March 5th 1971 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR QURESHI | | | | | | 23D. ADDRESS ST AGNES HOSPITAL BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/8/71 | | 24C. NAME of CEMETERY or CREMATORY BRIDGEVILLE CEMETERY | | 24D. LOCATION (City, town, or county) (State) BRIDGEVILLE, DEL. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR <i>Patel Qureshi</i> | | 25C. FUNERAL DIRECTOR HARDESTY | | ADDRESS BRIDGEVILLE, DEL. | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

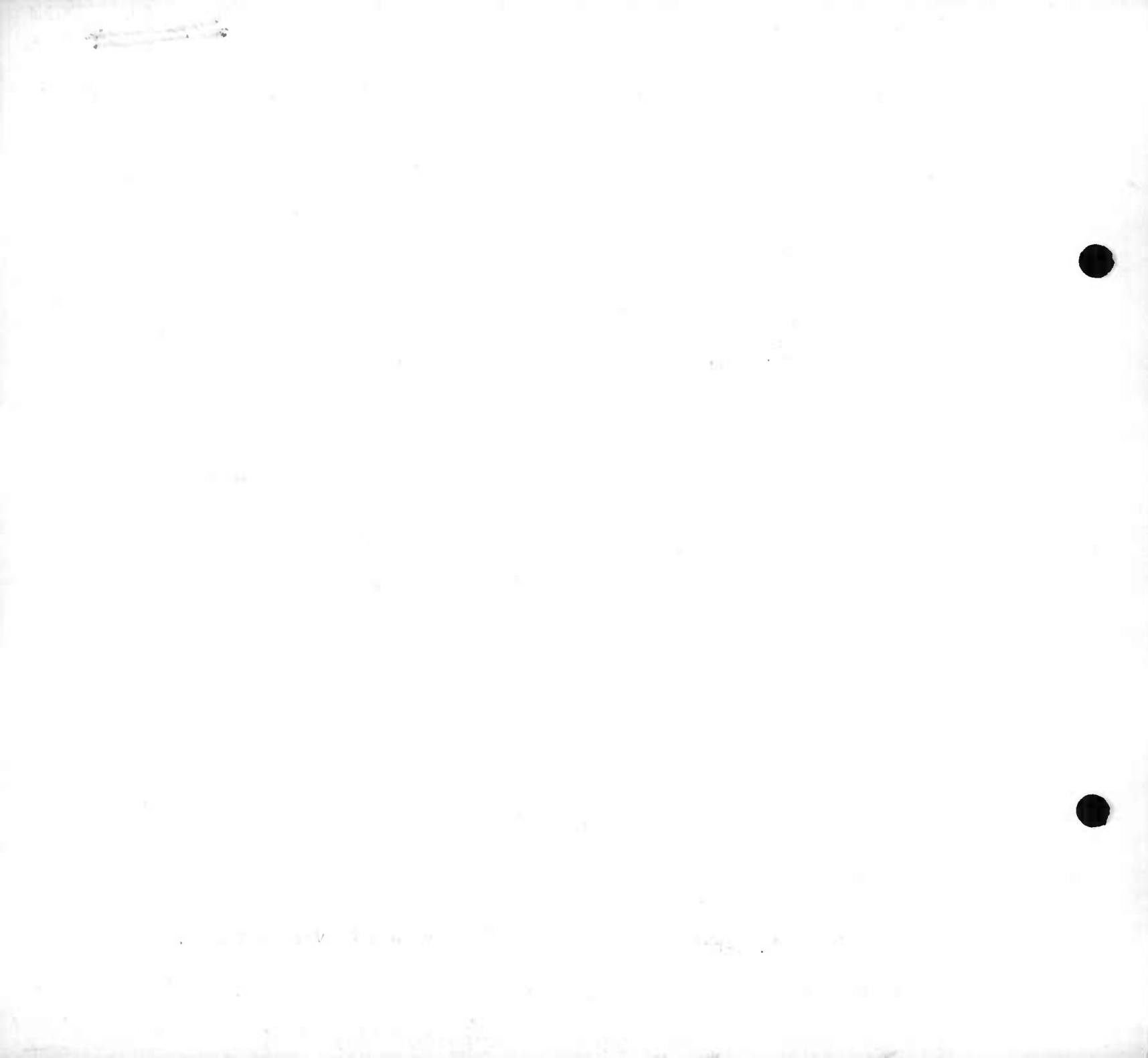
BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MINNIE WILLIAMS | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 3, 1971 6:30 A.M. | |
| 6. SEX Female | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE Negro | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 11/07/20 | | 10. AGE (In years last birthday) 50 | |
| 11. BIRTHPLACE (State or foreign country) Spartenburg, S. C. | | 12. CITIZEN OF USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Anne Allison, Balto., Md. | | 18. ADDRESS 2248 Linden Avenue 21217 | |
| 19. E93011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Bronchopneumonia and Cerebral Anoxia (A) IMMEDIATE CAUSE complicating cardiac arrest due to cardiac failure (B) suffered under anesthesia DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 1/6/71 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pyelolitholomy, Left Kidney | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? University Hospital | | 22F. HOW DID INJURY OCCUR? Therapeutic Misadventure | |
| 22D. TIME (Month) (Day) (Year) (Hour) 1-6-71 11:00 A.M. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/3/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/6/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR MORTON & DYETT FUNL HOME, INC. | | 25D. ADDRESS 1701-31 Laurens St., Balto., Md. 21217 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2255 | | CERTIFICATE OF DEATH | | REG. NO. [REDACTED] | |
|---|---|---|--|---|---|--|--|---|--|
| BIRTH NO. K-420 | | 1. NAME OF DECEASED (Type or Print) Robert Roulhac | | 2. DATE AND HOUR OF DEATH 3/4/71 12:15 AM | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Dukeland Nursing Home | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 603 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Dukeland Nursing Home | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER 418 Maderia Street | | | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/29/33 | 9. AGE (In years last birthday) 37 yrs. | 10. Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | 10B. KIND OF BUSINESS OR INDUSTRY N/A | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Willie Roulhac | | | | 14. MOTHER'S MAIDEN NAME Audrey Roulhac | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-286548 | | 17. INFORMANT 1501 N. Dukeland Street | | ADDRESS | | | |
| 18. 410.01 | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| <p>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | (A) IMMEDIATE CAUSE CORONARY OCCLUSION | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | (B) HYPERTENSIVE ENCEPHALOPATHY | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | (C) HYPERTENSION | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 2-22 19 71 to 3-4 19 71</p> <p>that (I) (we) last saw the deceased alive on 3-4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | | | | | |
| 23A. SIGNATURE Thomas W. Harris | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-4-71 | | | |
| 23C. PHYSICIAN'S NAME (Type) Thomas W. Harris | | | | 23D. ADDRESS 4200 Edmondson Ave, Balto, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3-8-71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md 2121 | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. [illegible] | | 25C. FUNERAL DIRECTOR Anthony Dyett F. H. | | ADDRESS 1701- [illegible] | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-346 71 2256 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2256 | |
|--|---------------------------|---|-----------------------------------|--|---|---|--|
| 1. NAME OF DECEASED (Type or Print) PHYLLIS BUTLER | | | | 2. DATE AND HOUR OF DEATH 3/5/71 5 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6 LUTHERAN HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE _____ B. COUNTY _____ C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 710 Walnut street | | | |
| 5. SEX FEMALE | 6. RACE NEGRESS | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-6-92 | | 9. AGE (in years last birthday) 78 | If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____ | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME N/A | | | | 14. MOTHER'S MAIDEN NAME Irene Gunther | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT Wilhelmina Spear ADDRESS CHART 710-Walnut Ave | | | |
| 18. 412-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE PREMATURE VENTRICULAR DUE TO, OR AS A CONSEQUENCE OF: (B) CONTRACTIONS & 1st HEART BLOCK DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO ATHEROSCLEROTIC HEART DISEASE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mins | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/3/71 to 3/5/71 that (I) (we) last saw the deceased alive on 3/5/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Azad Cader | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) AZAD CADER | |
| 23D. ADDRESS Lutheran Hospital, Balto, Md. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | |
| 24B. DATE 3-9-71 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | |
| 25B. NAME OF REGISTRAR Morton D. Goff | | 25C. FUNERAL DIRECTOR F.H. 1701-Lawrence St. | | 25D. ADDRESS 212-17 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

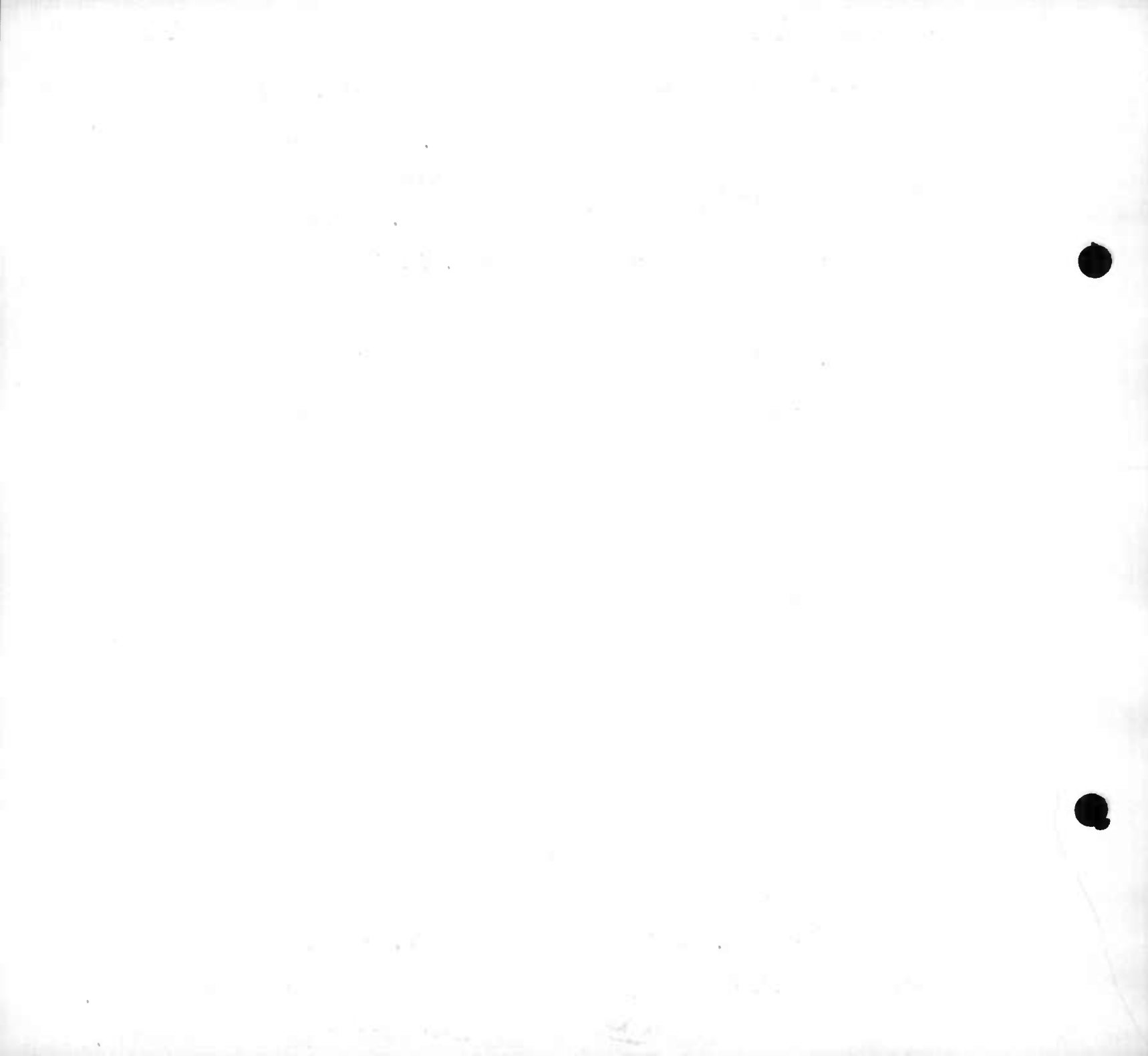
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2257 | |
|--|---|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> R-554 71 2257 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) JOSEPH L ROMANIELLO | | 2. DATE AND HOUR OF DEATH 3/5/71 10:50pm 10:50p M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 301 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital | | C. CITY OR TOWN Balto - 21231 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 427 S. Eden St. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 04-21-07 | 9. AGE (in years lost birthday) 63 | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Foreman | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. City | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Romaniello | | 14. MOTHER'S MAIDEN NAME Jennie Moscarriello Moscarriello | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218147160 | | 17. INFORMANT Sister ADDRESS same as above | |
| 18. 200.9 I CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute M.I. e heart block | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD (C) Diabetes Mellitus | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/27/71 1971 to 3/5/71 1971 that (I) (we) last saw the deceased alive on 3/5/71 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Pratima Bose MD | | 23B. DATE SIGNED 3/5/71 | | 23C. PHYSICIAN'S NAME (Type) PRATIMA BOSE MD | |
| 23D. ADDRESS Mercy Hospital | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | |
| 24B. DATE MAR 9 71 | | 24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM. | | 24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR R. L. ... | | 25C. FUNERAL DIRECTOR THE DIRPEL BROS INC | |
| 25D. ADDRESS 1800 E LOMBARD ST | | | | | |

THE UPPER BRONZE AGE
BURIAL - ROAD TO HOLY ROSEMARY CEM. 4000 YEARS OLD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

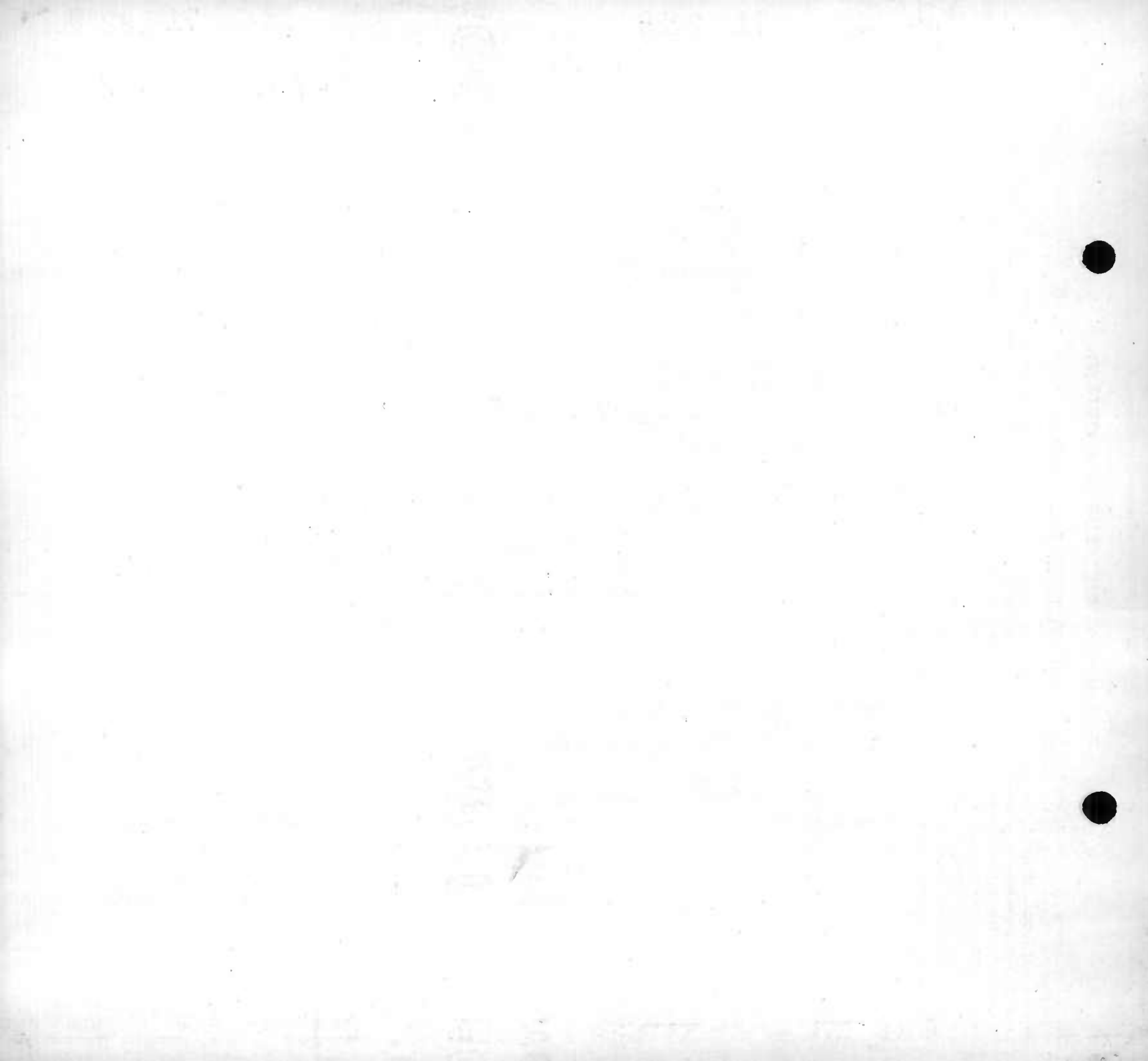
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2258</u> | |
|--|----------------------|--|--|---|---|
| G-600 <u>71 2258</u> | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. <u>1</u> | | 2. DATE AND HOUR OF DEATH <u>March 4, 1971 11:50 P.M.</u> | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Pearl Peddicord Gore</u> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Long Green Nursing Home</u> | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | C. CITY OR TOWN <u>Towson</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER <u>603 W. Joppa Road</u> | | | | | |
| 5. SEX <u>female</u> | 6. RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 13, 1885</u> | 9. AGE (In years last birthday) <u>85</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13. FATHER'S NAME <u>Issac H. Peddicord</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Waters</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no none</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Family records</u> | |
| 18. <u>4/23/180X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Carcinoma of cervix - radiation effect</u> | | 12 years? | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in at about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>Mar 4 1971</u> that (I) (we) last saw the deceased alive on <u>Feb 25 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Franklin E. Leslie</u> | | 23B. DATE SIGNED <u>3/8/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Franklin E. Leslie</u> | |
| 23D. ADDRESS <u>3501 St. Paul Street</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-8-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore City</u> | | (State) <u>Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>John Bluns Sons</u> | |
| | | | | ADDRESS <u>Towson Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| P-620 71 2258 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2258 | |
|--|---------------------|---|--|--|--|---|---|
| BIRTH NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) HENRY PEARCE | | | | 2. DATE AND HOUR OF DEATH 3/5/71 4:30 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Balto | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital | | | | C. CITY OR TOWN Balto | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 1752 E. 25th St. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-23-84 | | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Raleigh North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Oscar Pearce | | | | 14. MOTHER'S MAIDEN NAME Sally Ann | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 244-10-4288 | | 17. INFORMANT Chart, | | ADDRESS | |
| 18. 345.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: | | 8 | |
| | | | | (C) Grand mal seizure | | 8 | |
| II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Asthma, CHF | | yes | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from March 1 19 71 to March 5 19 71 , that (1) (we) last saw the deceased alive on March 5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Peter Densen | | | | 23B. DATE SIGNED 3/5/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) Peter Densen | | | | 23D. ADDRESS 601 N. Broadway, Balto, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/71 | | 24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, M | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Md. | | 25C. FUNERAL DIRECTOR Alphus Halstead | | ADDRESS 1206 W North Ave | |



1

T-460 71 2260 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 2260

BIRTH NO.

| | | | | |
|---|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) CAROL TAYLOR | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 5, 1971 | | Hour 10:45 P.M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year March 5, 1971 | | Hour 10:45 P.M. |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 802 | | | | |
| 6. SEX Female | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore |
| 9. DATE OF BIRTH 12/25/34 | | 10. AGE (In years last birthday) 36 | E. STREET AND NUMBER 2111 East North Avenue | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? | 13. FATHER'S NAME Edward Higgins | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 14B. KIND OF BUSINESS OR INDUSTRY | 15. MOTHER'S MAIDEN NAME Henne Jacobson | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. | 18. INFORMANT Wm. Taylor 1522 E. Biddle St | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head | | CAUSE OF DEATH Gunshot wound of head | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes (head-Only) |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2111 East North Avenue 802 |
| 22D. TIME (Month) (Day) (Year) (Hour) 3-5-71 9:40 A. m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Shot self |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | 3/6/71 |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/10/71 | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary | 24D. LOCATION (City, town, or county) (State) A.A. County, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | 25C. FUNERAL DIRECTOR Joseph H. Locks | ADDRESS 1304 N. Central Ave | |

VS 151-REV. 1/1/68

0835 15



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>71 2261</u> | |
|--|----------------------|---|--|--|---|
| BIRTH NO. <u>71 2261</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>MARY BELL SAMUELS FLORES</u> | | 2. DATE AND HOUR OF DEATH <u>3/6/71</u> <u>12 Noon</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>001628 N. CAROLINE ST</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>909</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u> D. STREET ADDRESS (If rural, give location) <u>1628 N. Caroline St</u> | | | |
| 5. SEX <u>F.</u> | 6. RACE <u>C.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u> | 8. DATE OF BIRTH <u>8/18/02</u> | 9. AGE (In years lost birthday) <u>68</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>ALA.</u> | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME <u>HENRY SAMUELS</u> | | | 14. MOTHER'S MAIDEN NAME <u>SARAH SAMUELS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>GWENDOLYN NICHOLS</u> ADDRESS <u>1628 N. Caroline St</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO <u>Bronchogenic Carcinoma</u> (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Arteriosclerotic Heart Disease</u> <u>YRS</u> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> 19 <u>70</u> to <u>March</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>2-27-</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>James McPhillips</u> | | | | 23B. DATE SIGNED <u>3/8/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JAMES MCPHILLIPS</u> | | | | 23D. ADDRESS M.D. <u>11 E Chase St Balto 21202</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/10/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u> | |
| 24D. LOCATION <u>Balto. MD</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Joseph H. Lock</u> | | 25D. ADDRESS <u>1304 N. Central</u> | |



C-100

71

2262

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71

2262

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CARLTON W. CUFFIE

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

March 5, 1971

9:21 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

33 JOHNS HOPKINS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

March 5, 1971

9:21 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1001

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

April 4, 1954

10. AGE (In years
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1235 Harford Avenue

11. BIRTHPLACE (State or foreign country)

Balto. Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Cuffie

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

Dunbar High

15. MOTHER'S MAIDEN NAME

Christina Cuffie

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

James Cuffie 1232 Harford Ave

ADDRESS

19. E 965 X

CAUSE OF DEATH

Gunshot wound of back

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

House

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1202 Aisquith Street, 3rd floor

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 3-5-71 8:36 P. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate, M.D.

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/6/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/9/71

24C. NAME OF CEMETERY or CREMATORY

Balto. National

24D. LOCATION (City, town, or county) (State)

5501 Frederick Ave

25A. DATE REC'D BY HEALTH DEPT.

MAR 8, 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

Joseph K. Locke, Jr.

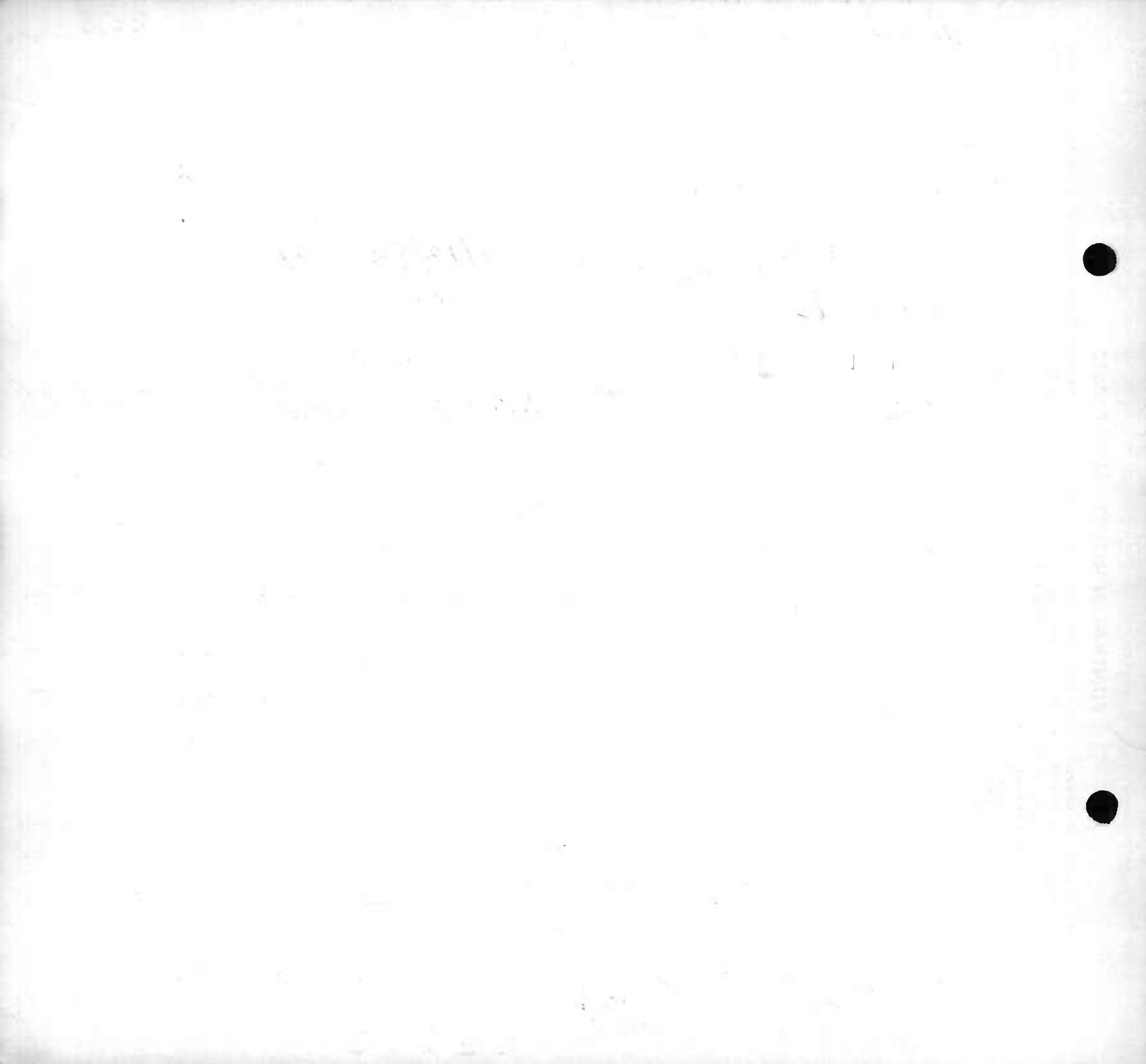
ADDRESS

1304 N. Central

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2263 | | 71 2263 | |
|---|--|--|--|---|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | ANNIE A. MOORE | | 3/6/71 1 6 35 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE B. COUNTY | | 808 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| JOHNS HOPKINS HOSPITAL | | | | BALTIMORE | | 1029 RUTLAND AVE. | |
| 5. SEX FEMALE | | 6. RACE NEGROE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1/12/80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) 91 | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 13. FATHER'S NAME WILLIAM BRISCOE | | 14. MOTHER'S MAIDEN NAME PRISCILLA | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 216 09 9774 | | 17. INFORMANT Louise Brown | | ADDRESS 1029 Rutland AP | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA 4 days | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA- | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/27 19 71 to 3/6 19 71 that (I) (we) last saw the deceased alive on 3/6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE J. S. Kuzi MD | | | | 23B. DATE SIGNED 3/6/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 3/10/71 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Zion | |
| 24D. LOCATION (City, town, or county) (State) Baltimore MD | | | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | | | 25C. FUNERAL DIRECTOR Joseph E. Locks | | | |
| 25D. ADDRESS 1304 N. Central Ave | | | | | | | |



B-620

71

2264

BALTIMORE CITY HEALTH DEPARTMENT

71

2264

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) WILLIE BROCK Jr | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year 3 5 1971 3:50 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year 3 5 1971 3:50 a.m. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 9/2/52 | | 10. AGE (In years lost birthday) 18 | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestication | | 14B. KIND OF BUSINESS OR INDUSTRY J. H. Hosp | |
| 15. MOTHER'S MAIDEN NAME Bernadine Barrett | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Emeline Brock 2019 N. Wolfe St | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E890X | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Conflagration DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1818 N. Broadway | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 3/5/71 3:23 a.m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Subj. trapped in house fire. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/5/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Balto. National | | 24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | |
| 25C. FUNERAL DIRECTOR Joseph G. Lock | | ADDRESS 1304 N. Central Ave | |

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VALLEY

John

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B6 23

71 2265

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2265

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BRUCE B. BRISTOL

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month Day

3-6-71

Year

Hour

3:21 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

LUTHERAN HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month Day

March 6, 1971

Year

Hour

3:21 A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

2002

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

May 18, 1950

10. AGE (In years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

405 Poplar Grove Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Raymond Bristol

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Louise A. Breadman

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Louise A. Breadman Bristol, 405 Poplar Grove

ADDRESS

19. E9651
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Gunshot wound of chest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

?

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Edmondson Ave. and Poplar Grove St.

22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

3-6-71 A.M.

m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Charles S. Springate, M.D.
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/6/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/10/71

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

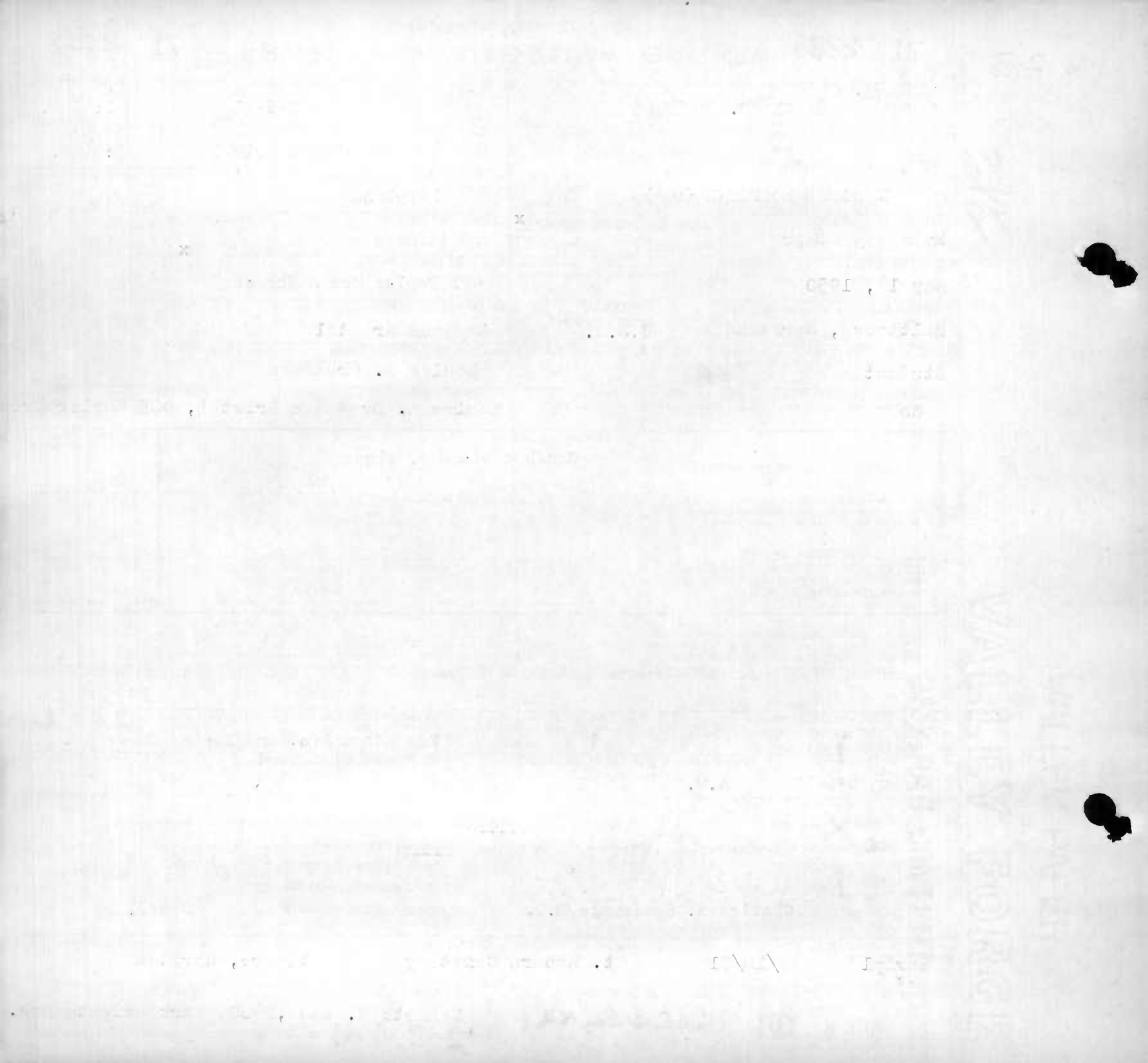
ADDRESS

MAR 8 1971

Robert E. Taylor, M.D.

Kenneth H. Law

4609 Park Heights Ave.



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71 2266

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2266

| | | | |
|---|--|--|--|
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) WINSTON STOKES | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 707 N. Broadway | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 2, 1971 3:42 P. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 7/20, 1926 | | 10. AGE (In years lost birthday) 44 | |
| 11. BIRTHPLACE (State or foreign country) Greenbay, Va. | | 12. CITIZEN OF U.S.A. | |
| 13. FATHER'S NAME William Stokes | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman J.F.K. Memorial Institute | |
| 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) (If yes, give war or dates of service) Yes W.W.II | |
| 17. SOCIAL SECURITY NO. 226-28-8227 | | 18. INFORMANT Mary A. Stokes, 705 Cumberland St. | |
| 19. 4/12/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 22A. DATE OF OPERATION | | 22B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22E. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 24. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | DATE SIGNED 3/3/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/6/71 | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Kenneth H. Law | | ADDRESS 4609 Park Heights Ave. | |

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condition

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-452 71 2267 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2267 | |
|---|---|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) ALBERT W. REULING | | 2. DATE AND HOUR OF DEATH 3-6-71 8²⁵ P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2003 | | C. CITY OR TOWN BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSP. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 109 S. PAYSON ST. | |
| 5. SEX M | 6. RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-06-87 | 9. AGE (In years last birthday) 83 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY RETIRED | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-05-3011 | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD - Congestive Heart Failure | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD - Congestive Heart Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANEMIA, etiology unknown NEPHROTIC SYNDROME. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) NO | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-30-71 to 3-6-71 that (I) (we) last saw the deceased alive on 3-6-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Oscar E. Ferdinandini M.D. | | 23B. DATE SIGNED 3-6-71 | | 23C. PHYSICIAN'S NAME (Type) OSCAR E. FERNANDINI M.D. | |
| 23D. ADDRESS BON SECOURS HOSP.; BALTO., MD. | | 23E. NAME OF REGISTRAR | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE March 10-71 | 24C. NAME OF CEMETERY OR CREMATORY Louisa Park | 24D. LOCATION (City, town, or county) (State) Baltimore MD | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | |
| 25B. NAME OF REGISTRAR George H. Schwab | | 25C. FUNERAL DIRECTOR ADDRESS 2101 Frederick Ave | | | |



| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
|---|--|--|--|------------------------------------|--|---|--|--|--|
| JOHN E. COCHRAN | | Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year Hour | | Month Day Year Hour | | A. STATE B. COUNTY | |
| 001927 Frederick Ave. | | 3 5 1971 10:40 a.m. | | Md. | | 2003 | | | |
| 6. SEX 7. RACE 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | | E. STREET AND NUMBER | | F. FATHER'S NAME | | G. MOTHER'S MAIDEN NAME | |
| male white WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Balto. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1927 Frederick Ave. | | | | | |
| 9. DATE OF BIRTH 10. AGE (In years last birthday) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 7/1/10 60 | | Prince Frederick, Md. | | USA | | | | Casher | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. ADDRESS | | 19. CAUSE OF DEATH | |
| No | | 217-07-2354 | | Mrs. Ruth Cochran | | 1927 Frederick Ave. | | Arteriosclerotic cardiovascular disease | |
| 20. DATE OF OPERATION | | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22. AUTOPSY? (Yes or No) | | 23. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 0 | | | | no | | | | 25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 26. TIME OF INJURY (Approx.) | | 27. INJURY OCCURRED | | 28. HOW DID INJURY OCCUR? | | 29. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 22D. (Month) (Day) (Year) (Hour) | | 22E. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 31. ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | 32. DATE SIGNED | |
| | | | | | | Isidore Mihalakis, M.D. | | 3/5/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | |
| Burial | | 3/8/71 | | Cedar Hill Cemetery | | Baltimore, Md. | | MAR 8, 1971 Robert E. Faber, MD | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |
| Robert E. Faber, MD | | George L. Schwab, Inc. | | | | | | | |

[Faint, illegible handwritten text]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| T-246 71 2269 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2269 | |
|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>TEGELER, Mrs Louise W.</u> | | | | 2. DATE AND HOUR OF DEATH <u>February 28, 1971</u> <u>3:05</u> <u>AM.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>1903</u> | | | |
| 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <u>10-03-17</u> | | 9. AGE (In years last birthday) <u>53</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Clerk</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u> | |
| 13. FATHER'S NAME <u>Irwin</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>216-24-4205</u> | | 17. INFORMANT <u>Mrs. Donna Godwin</u> ADDRESS <u>332 S. Monroe St. Balto. Md. 21223</u> | |
| 18. <u>45791</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebro Vascular Accident.</u> (B) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Pylonephritis, acute.</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>FEB 15</u> 19 <u>71</u> to <u>FEB 28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3:00 am FEB 28</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Manuel Galdos</u> | | | | DEGREE <u>DEGREE</u> | | 23B. DATE SIGNED <u>FEB 28/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Manuel Galdos</u> | | | | 23D. ADDRESS <u>Bon Secours Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/4/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Rev. J. A. Church, Jr.</u> | | ADDRESS <u>2101 Midway Ave. Balto. Md. 21223</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

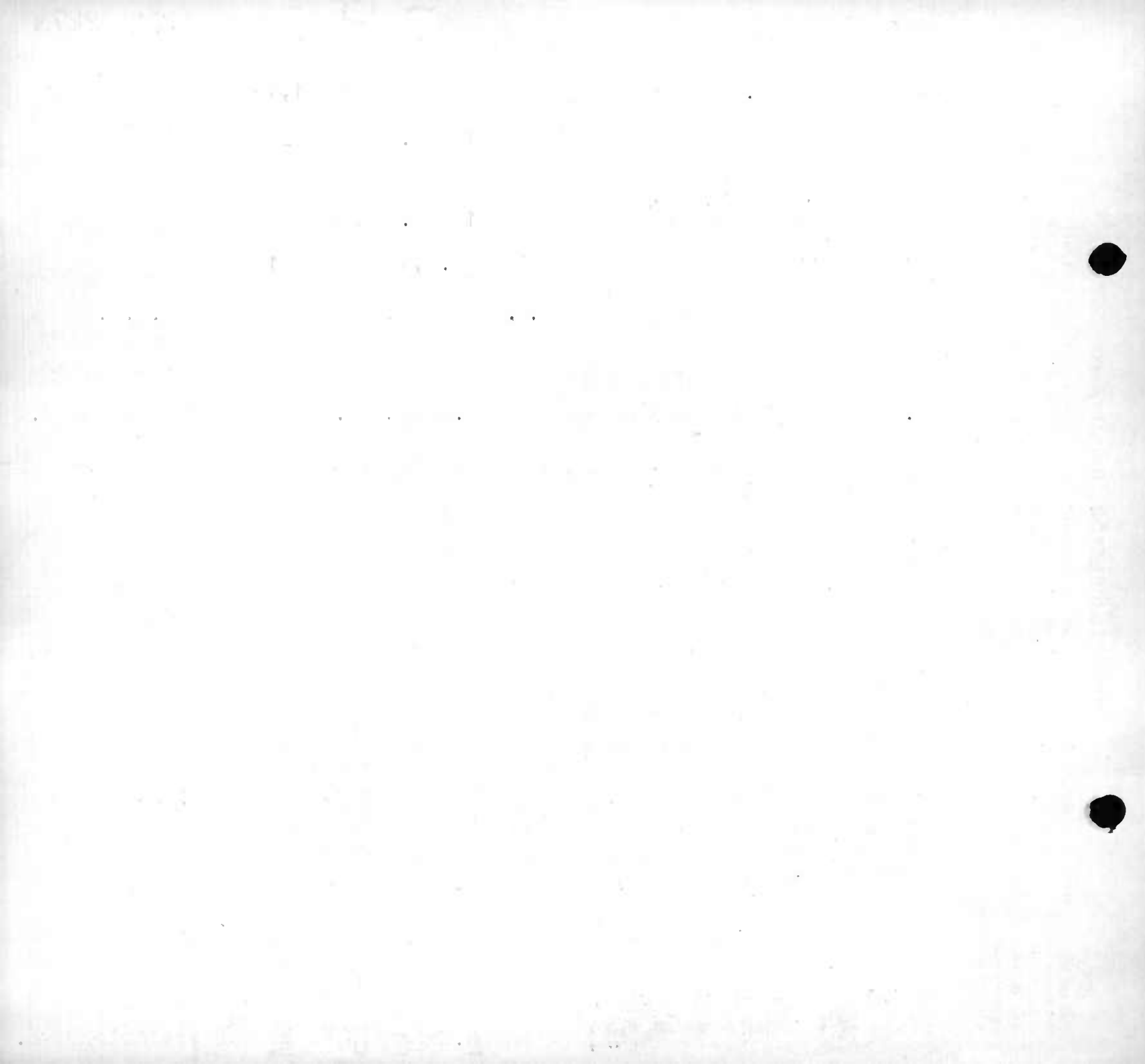
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2270</u> | |
|---|--|---|---|--|--|
| BIRTH NO. <u>71 2270</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Harp George M.</u> | | | 2. DATE AND HOUR OF DEATH <u>3-6-71</u> <u>4 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1903</u> | | |
| 5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 8. DATE OF BIRTH <u>12-03-13</u> 9. AGE (in years last birthday) <u>57</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | |
| 13. FATHER'S NAME <u>Marion Harp</u> | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Owens</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u> | | | 16. SOCIAL SECURITY NO. <u>217-03-8854</u> | | |
| 17. INFORMANT <u>Chart</u> | | | ADDRESS | | |
| 18. <u>204.1 I</u> CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last | | | (A) IMMEDIATE CAUSE <u>Bronchopneumonia with</u> DUE TO, OR AS A CONSEQUENCE OF <u>Septicemia</u> (B) <u>Chronic lymphatic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>2-22</u> 19 <u>71</u> to <u>3-6</u> 19 <u>71</u> that (2) (we) last saw the deceased alive on <u>3-6</u> 19 <u>71</u> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>H. deBorja M.D.</u> | | | 23B. DATE SIGNED <u>3-5-71</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Lilia LoFranco-deBorja M.D.</u> | | | 23D. ADDRESS <u>Bon Secours Hospital Balto, Md. 21223</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-9-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem</u> | |
| 24D. LOCATION (City, town, or county) <u>MA Co.</u> | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 24G. DATE REC'D BY HEALTH DEPT. <u>MAR 8, 1971</u> | | 24H. NAME OF REGISTRAR <u>Robert J. ...</u> | | 24I. FUNERAL DIRECTOR <u>Garf Schmitt</u> | |
| 24J. ADDRESS | | 24K. ADDRESS | | 24L. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

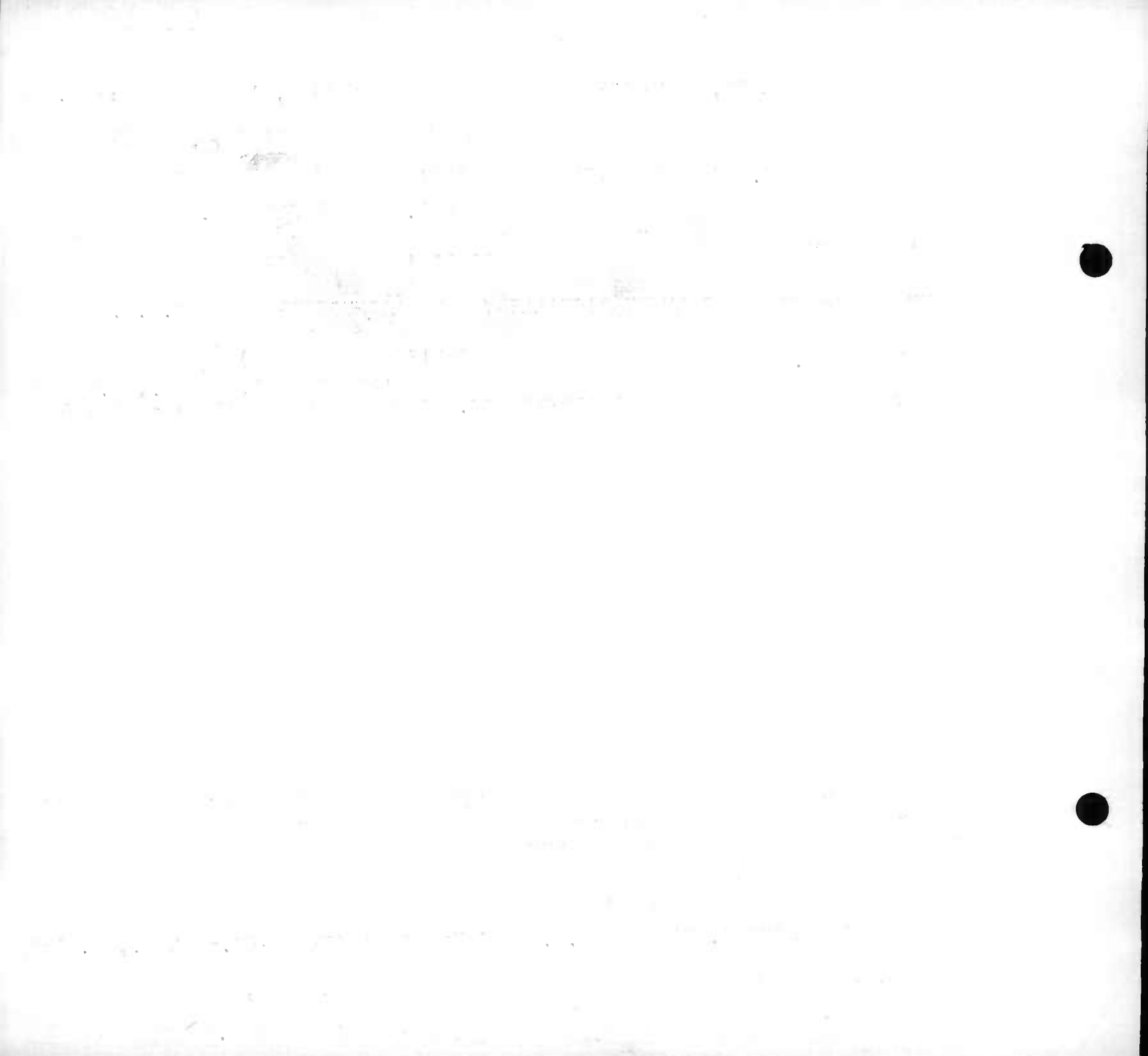
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | 71 2271 | |
|---|--|--|--|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> W-534 71 2271 </div> | | | | <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> | | | |
| 1. NAME OF DECEASED (Type or Print) Brenty L. Windle | | | | 2. DATE AND HOUR OF DEATH March 1, 1971 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 127 S. Monastery Ave. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 127 S. Monastery Ave 2047 | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 2, 1880 9. AGE (In years last birthday) 91 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor | | | | 10B. KIND OF BUSINESS OR INDUSTRY Contracting Bus. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Unknown | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 218-03-5068A | | | |
| 16. SOCIAL SECURITY NO. 218-03-5068A | | | | 17. INFORMANT Mr. James J. Kaehler 46 Upmanor Rd. | | | |
| 18. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.P.C.V.P. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 2:30 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to Mar 1, 1971 , that (I) (we) last saw the deceased alive on 3/1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE J. C. Pound | | | | 23B. DATE SIGNED 3/3/71 | | 23C. PHYSICIAN'S NAME (Type) J. C. Pound | |
| 23D. ADDRESS 3325 Frederick Ave | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 3-4-1971 | | 24C. NAME OF CEMETERY or CREMATORY London Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR G. Truman Schwab | | | |
| ADDRESS 3512 Frederick Ave. | | | | | | | |



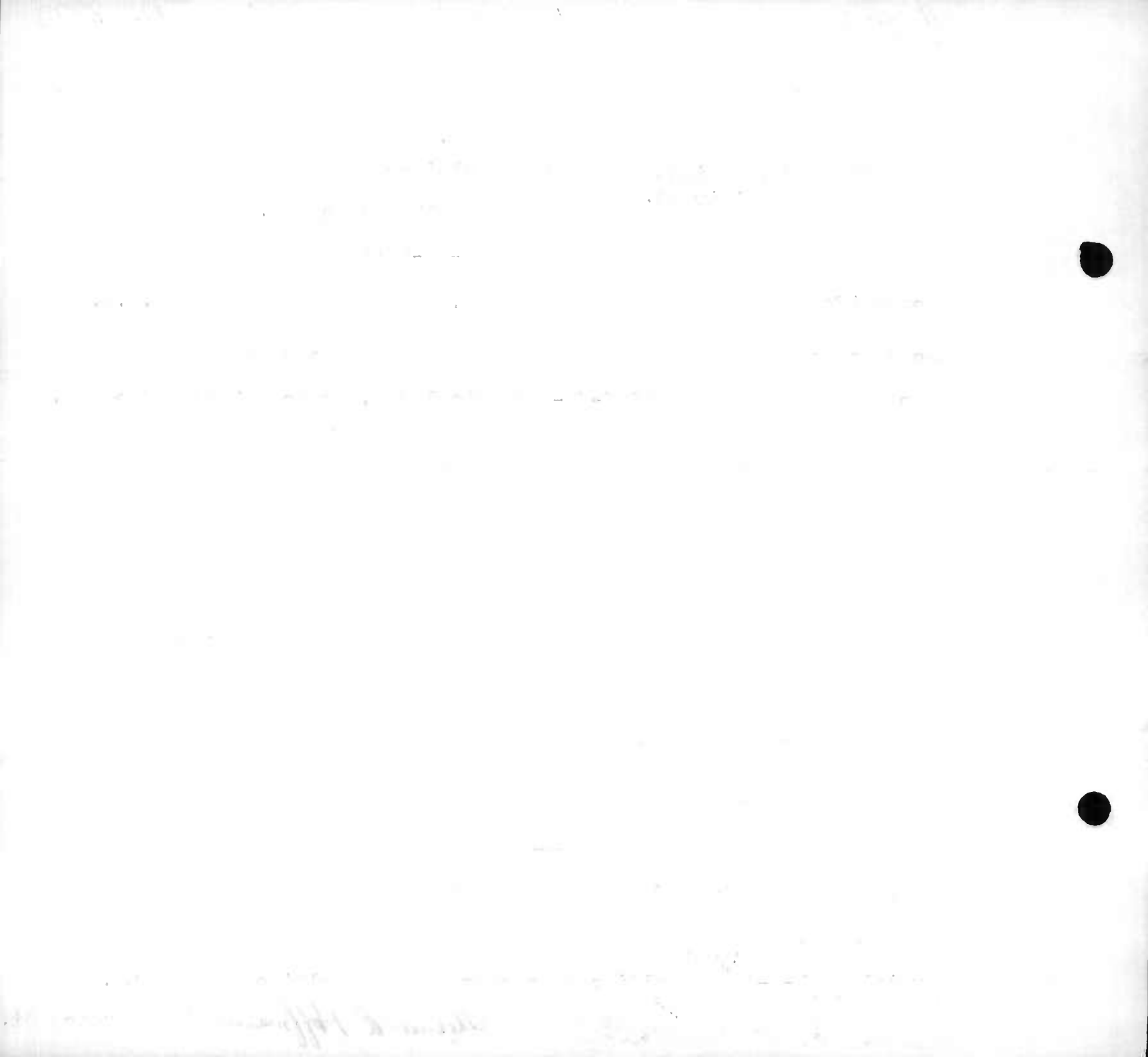
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2272</u> | |
|--|---------------|--|---------------------------|--|--|
| S-530 71 2272 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| SMITH, ROY RICHARD | | MARCH 2, 1971 1:55A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL | | A. STATE MARYLAND B. COUNTY CITY 21229 | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 40 | | E. STREET AND NUMBER 594 S. BEECHFIELD AVE. 2531 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 01 11 16 | 9. AGE (In years last birthday) 55 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| XXX WAREHOUSEMAN | | CALVERT DISTILLERY | | MASSACHUSETTS | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Richard M. Smith | | Mansfield NELLIE (Mary) x Raddx | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES 1945 | | 019037570 | | WILKENS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON & | |
| 18. 4/10/91 | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Acute Hemiparalysis hours | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | Acute Myocardial infarction hours | |
| ANTECEDENT CAUSES | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | with Rupture hours | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | ASCVD - old infarct | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 2 19 71 to MARCH 2 19 71 that (I) (we) last saw the deceased alive on MARCH 2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| Perfecto C. Valarao | | 3-2-71 | | PERFECTO C. VALARAO M.D. | |
| 23D. ADDRESS | | 23E. ADDRESS | | | |
| CATON & WILKENS AVES. - BALTO., MD. 21229 | | CATON & WILKENS AVES. - BALTO., MD. 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3/6/1971 | | Loudon Park | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. LOCATION (City, town, or county) (State) | | | |
| Baltimore, Maryland | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 8 1971 | | Robert E. Valarao | | 512 Frederick Ave G. Truman Schwab | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | | |
|--|--|--|------------------|--|--|--|--|--|------------------------------------|---|--|---|--|--|--|--|--|------------------------|--|--|
| 71 2273 CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | |
| REG. NO. 71 2273 | | | | | | | | | | | | | | | | | | | | |
| BIRTH NO. 4-350 | | | | | 1. NAME OF DECEASED (Type or Print) AGNES A. HATTON | | | | | 2. DATE AND HOUR OF DEATH 3/4/71 12:50 P.M. | | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House Of The Pines Belair Rd. | | | | | | | | | | A. STATE Md. | | | | | B. COUNTY 101 | | | | | |
| | | | | | | | | | | C. CITY OR TOWN Baltimore | | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| | | | | | | | | | | E. STREET AND NUMBER 3024 Hudson St. | | | | | | | | | | |
| 5. SEX F | | | 6. RACE W | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 11-12-1883 | | | 9. AGE (In years lost birthday) 87 | | | 11. Under 1 Yr. Months: Days: Hours: Min. | | | 12. Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) Md. | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | |
| 13. FATHER'S NAME John Hanna | | | | | | | | | | 14. MOTHER'S MAIDEN NAME Schurman | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | | | | | | 16. SOCIAL SECURITY NO. m215-52-0621 | | | | | | | | | | |
| 17. INFORMANT Charles F. Hatton | | | | | | | | | | ADDRESS 3024 Hudson St. | | | | | | | | | | |
| 18. 437.91 CAUSE OF DEATH | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | (A) IMMEDIATE CAUSE Multistyle Stroke months | | | | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (B) Arteriosclerotic Cardiovascular Disease years | | | | | | | | | | |
| | | | | | | | | | | (C) | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Coronary Artery Disease, Chronic | | | | | | | | | | months | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/2/71 to 3/4/71 that (I) (we) last saw the deceased alive on 3/2/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Albert O. Bulley | | | | | | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED 3/4/71 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | 23D. ADDRESS | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 24B. DATE 3-8-71 | | | | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | | | | |
| 24D. LOCATION (City, town, or county) Baltimore | | | | | | | | | | (State) Md. | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | | | 25C. FUNERAL DIRECTOR Thelma R. Hoffman | | | | | ADDRESS 3218 Hudson St. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

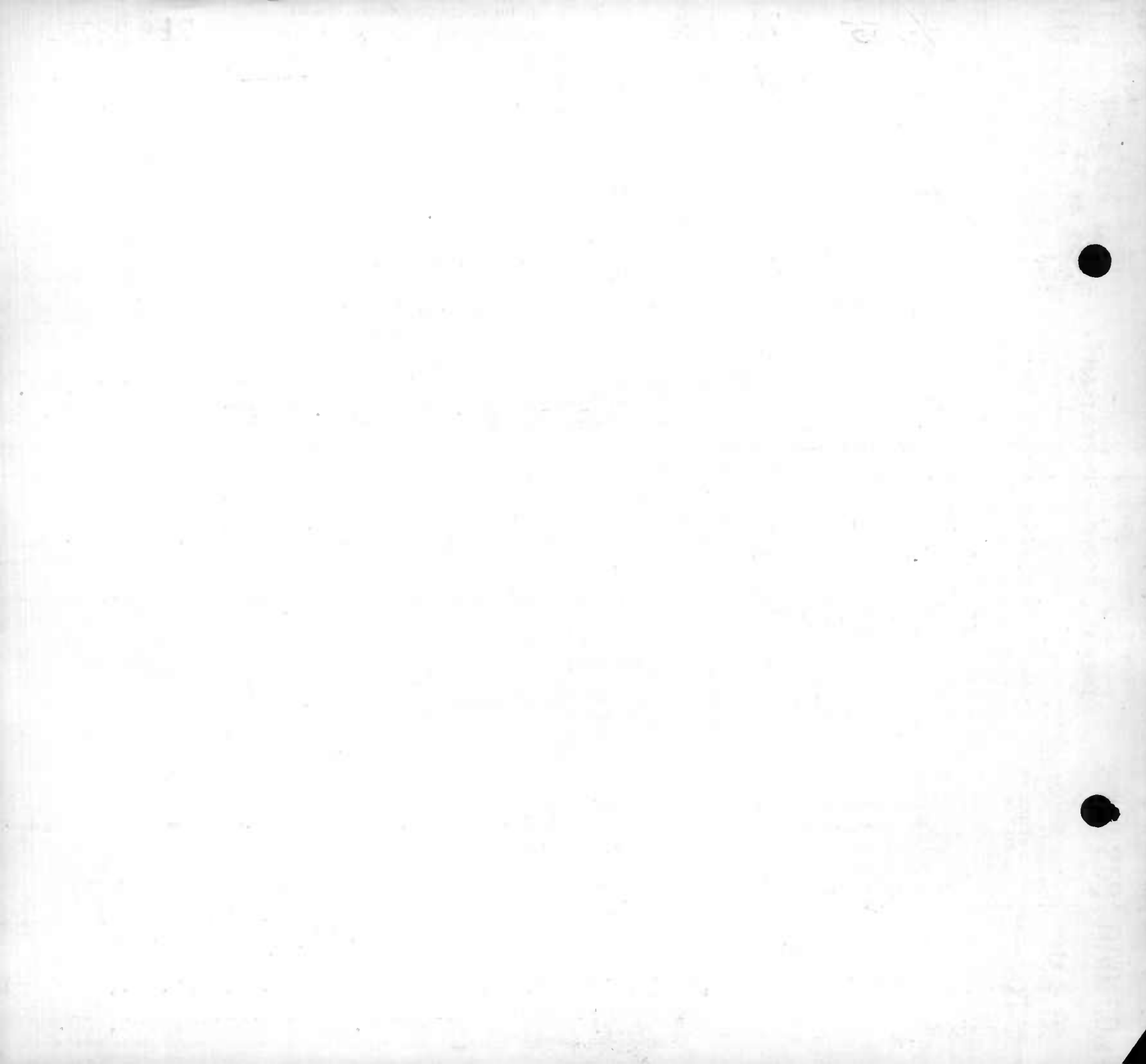
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---------|--|--|--|--------------------|--|
| C-516 | | 71 2224 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 71 2224 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) CHAMBERS, GORDON | | | |
| 2. DATE AND HOUR OF DEATH 3/4/71 10:50 P.M. | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD North Charles General Hospital | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE | | | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hospital | | | |
| 6. CITY OR TOWN City | | | | 7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 8. STREET AND NUMBER 2711 Arbutus AVE. 5300 | | | | 9. AGE (In years last birthday) 72 | | | |
| 10. SEX M. 11. RACE W. 12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 13. DATE OF BIRTH Oct. 25 '1888 | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee | | | | 15. KIND OF BUSINESS OR INDUSTRY Balto. Transit | | | |
| 16. BIRTHPLACE (State or foreign country) Baltimore | | | | 17. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 18. FATHER'S NAME Charles Chambers (D) | | | | 19. MOTHER'S MAIDEN NAME Virginia Phelps (D) | | | |
| 20. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 21. SOCIAL SECURITY NO. 212-10-5880 | | | |
| 22. ADDRESS 2711 Arbutus Ave. | | | | 23. INFORMANT Mary Chambers | | | |
| 24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Lung Cancer | | | | 25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the underlying condition lost 14- | | | |
| 26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | 27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 28. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 3/2/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Lung Cancer 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | 22. I certify that (I) (this hospital) attended the deceased from 2/25 19 71 to 3/4 19 71 that (I) (we) last saw the deceased alive on 3/4 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE M. H. KELEMEN | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) M. H. KELEMEN | | | | 23D. ADDRESS North Charles General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 3/8/71 | | | |
| 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Ritchie Highway A.A.Ct. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | | 25B. NAME OF REGISTRAR RAO | | | |
| 25C. FUNERAL DIRECTOR KRAUSE FUNERAL HOME | | | | 25D. ADDRESS 1216S. Charles St. | | | |

FUNERAL DIRECTOR: IMPORTANT

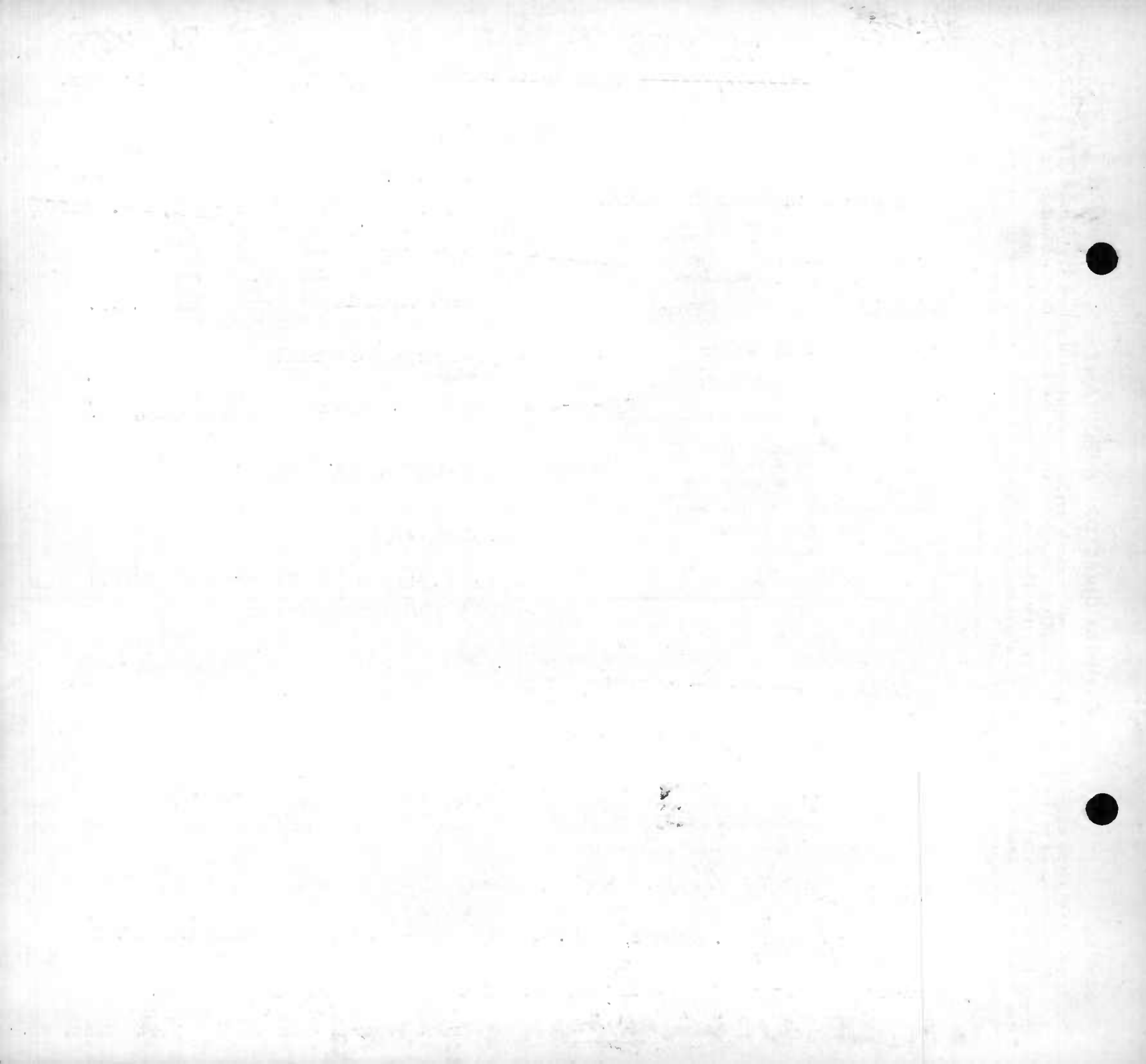
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|----------------------------------|--|---|--|--------------------|--|
| 4-153 71 2275 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | X REG. NO. 71 2275 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) ANNA HOFFMAN | | | |
| 2. DATE AND HOUR OF DEATH 2/27/71 1:30 A.M. | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3 THE JOHNS HOPKINS HOSPITAL | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY WASHINGTON 7100 | | | | C. CITY OR TOWN WILLIAMSPORT D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 3 W. POTOMAC STREET | | | | 5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 3-26-93 9. AGE (In years last birthday) 77 | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY At Home | | | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME MARTIN SMALL 14. MOTHER'S MAIDEN NAME IDA BELL KIRKPATRICK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. D 216-14-6067 | | | | 17. INFORMANT ADDRESS 2460 Virginia Ave. Mr. Charles A. Reichter Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: achalasia, dehydration 3 months (B) adenocarcinoma of stomach 6 months (C) thyroid carcinoma | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | | | 22. I certify that (I) (this hospital) attended the deceased from 1/31 1971 to 2/27 1971, that (I) (we) last saw the deceased alive on 2/27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE James C. Bobrow M.D. 23B. DATE SIGNED 2/27/71 | | | | 23C. PHYSICIAN'S NAME (Type) James C. Bobrow M.D. 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE March 3, 1971 24C. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery 24D. LOCATION (City, town) or county (State) Hagerstown, Wash. Co., Maryland | | | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport, Md. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

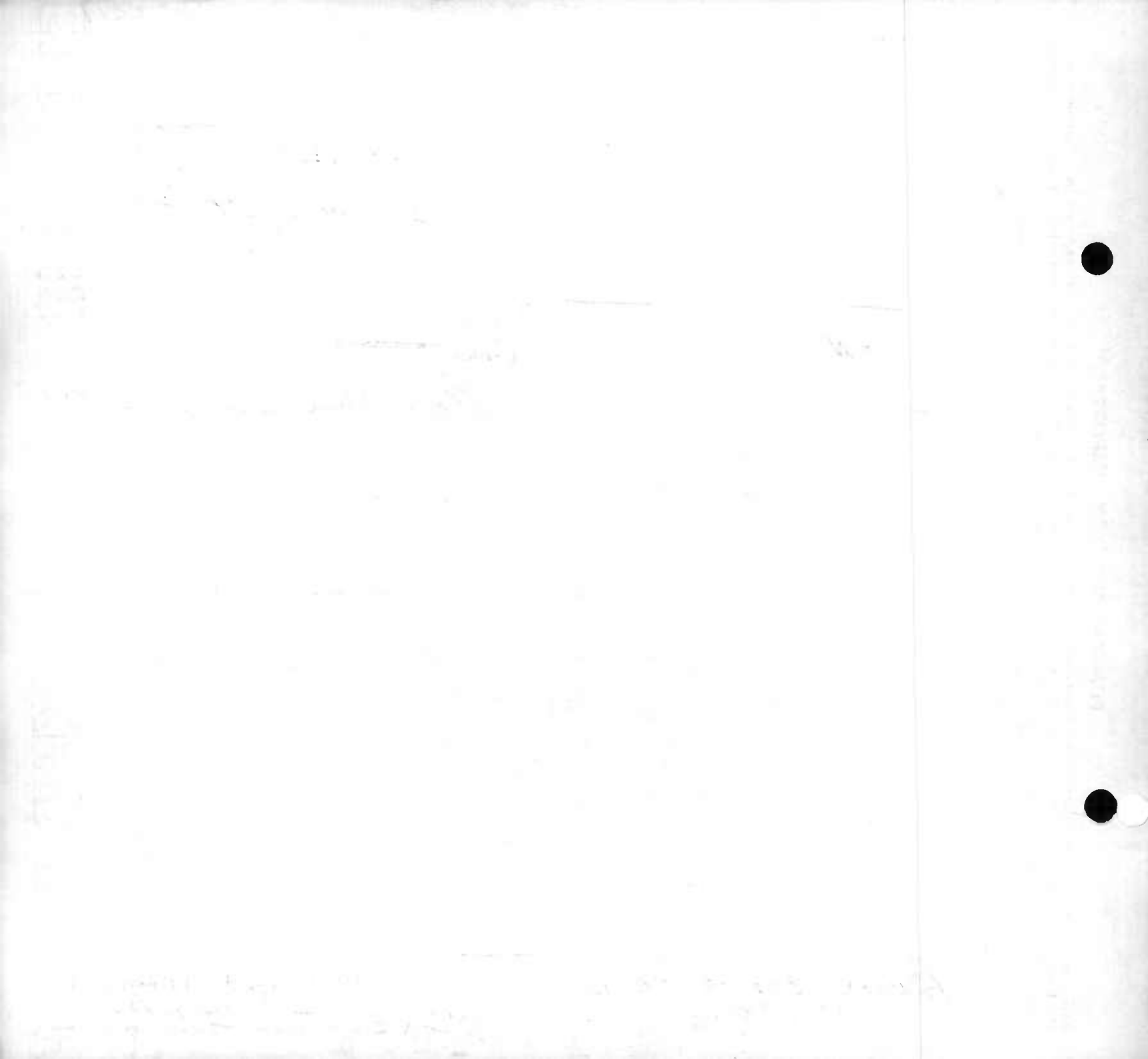
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2276 | |
|---|--------------------------------|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) L-236 LESTER, Lella Essie Lella Lester | | 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 3/4/71 3:50 a. M. </div> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Cecil C. CITY OR TOWN Northeast D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER P.O. Box 139 Northeast, Md. 21901 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/20/25 | 9. AGE (In years last birthday) 45 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME England Lester | | |
| 14. MOTHER'S MAIDEN NAME Margaret Steele | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 236-32-1446 | | | 17. INFORMANT Remley E. Lester Box 139 North East, Md. | | |
| CAUSE OF DEATH | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 3/1/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Elective 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED White At <input type="checkbox"/> Nat White At <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that 1X (this hospital) attended the deceased from 2/20 19 71 to 3/4/71 19 71 that 1X (we) lost saw the deceased alive on 3/4/71 19 71 and that in 1X (our) opinion death occurred on the date and hour end from the causes stated above. 1X (We) (did) (did not) view the body after death. 23A. SIGNATURE Arnold W. Kwart, M.D. 23B. DATE SIGNED 3/4/71 23C. PHYSICIAN'S NAME (Type) Arnold W. Kwart, M.D. 23D. ADDRESS J. H. H. Johns Hopkins Hospital 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3-7-71 24C. NAME of CEMETERY or CREMATORY North East Methodist 24D. LOCATION (City, town, or county) (State) North East Md. 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR Grant Funeral Home ADDRESS North East, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

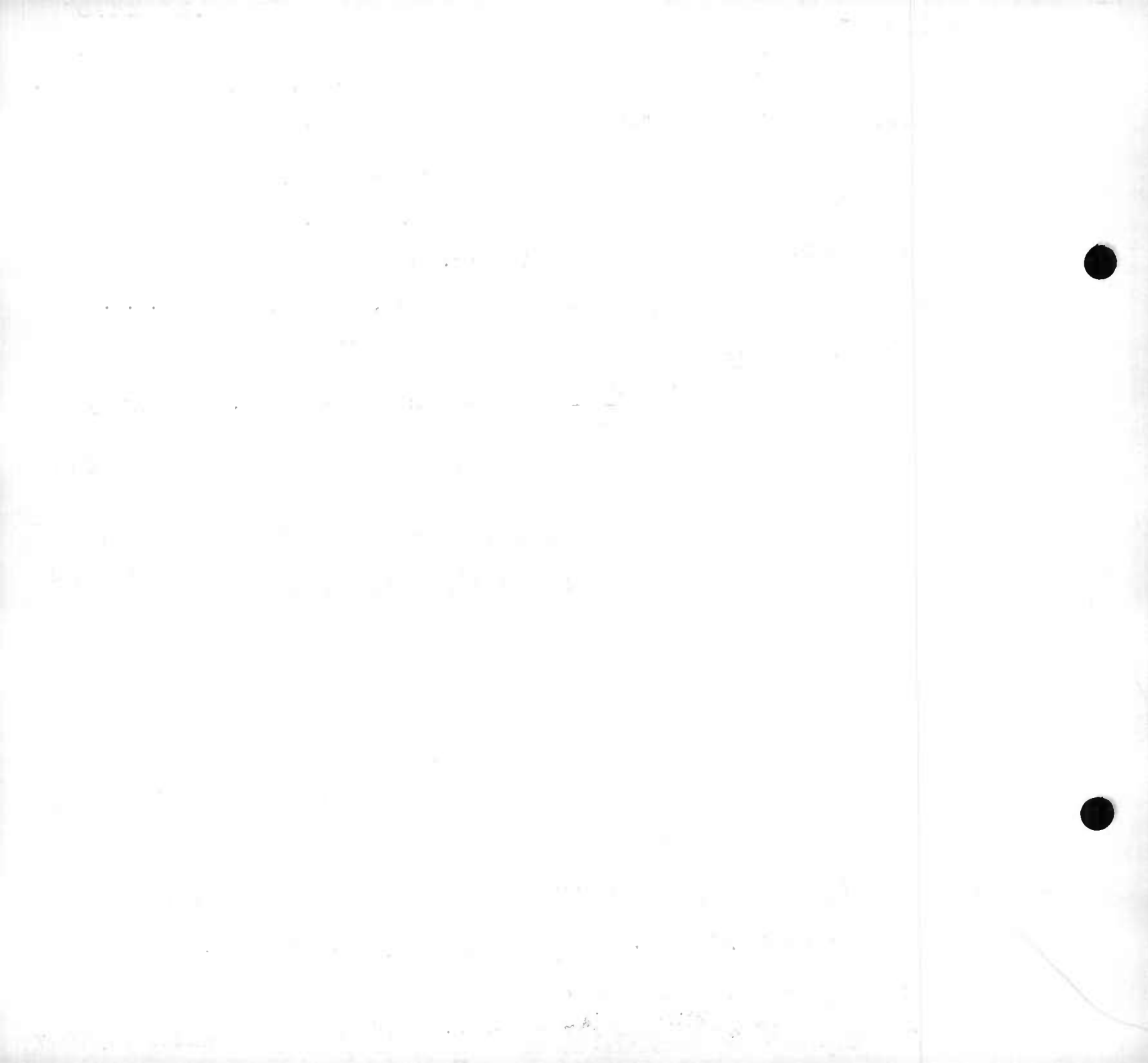
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | X | | REG. NO. <u>71 2277</u> | |
|---|--|---|--|---|--|---|--|---|--|
| BIRTH NO. <u>11-635</u> | | 1. NAME OF DECEASED (Type or Print) <u>MARTIN, LOLA E.</u> | | 2. DATE AND HOUR OF DEATH <u>3-7-71 2:30pm.</u> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> <u>44</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> <u>5100</u> | | C. CITY OR TOWN <u>Westport</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX <u>F</u> 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8/13/91</u> | | 9. AGE (in years last birthday) <u>79</u> | | 10. UNDER 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. STATES</u> | | | |
| 13. FATHER'S NAME <u>JOHN MARTIN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Grace Lillian DAWSON</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>213-22-3228</u> | | | | 17. INFORMANT <u>Masonic Home, Cockeysville, Md.</u> | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Probably Gastrointestinal</u> <u>mal bleeding or Cerebrovascular accident</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-6</u> 19 <u>71</u> to <u>3-7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3-7</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Juan M. Calderon</u> | | | | 23B. DATE SIGNED <u>3-7-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>JUAN M. CALDERON</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | |
| <u>Burial</u> | | <u>3-10-1971</u> | | <u>Philos.</u> | | <u>Westport, Maryland</u> | | 25B. NAME OF REGISTRAR | |
| <u>MAR 8 1971</u> | | <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR | | ADDRESS <u>1050 York Rd</u> <u>Wm Cook-Brooks-Townson</u> <u>Towson MD 21204</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2278 |
|---|--|--|--|----------------|
| CERTIFICATE OF DEATH | | | | REG. NO. _____ |
| BIRTH NO. C-425 | | 71 2278 | | |
| 1. NAME OF DECEASED (Type or Print) Jerry Canfield Coulson | | 2. DATE AND HOUR OF DEATH March 5, 1971 10:30 P. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Keswick: Home for Incurables | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 91 Keswick | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 5. SEX Male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH Sept. 2, 1929 9. AGE (in years last birthday) 41 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager | | 10B. KIND OF BUSINESS OR INDUSTRY Buisness Forms | | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Marshall VanMeter Coulson | | 14. MOTHER'S MAIDEN NAME Julia Hoblitzell | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. 220-24-9125 | | |
| 17. INFORMANT Records: Keswick | | ADDRESS 700 W. 40th Street | | |
| 18. CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 340X1 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE Septicemia DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (B) Chronic urinary tract infection DUE TO, OR AS A CONSEQUENCE OF: 10 yrs | | |
| | | (C) Multiple Sclerosis DUE TO, OR AS A CONSEQUENCE OF: 12 yrs | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION ○ | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 17 Sept. 1962 to 5 Mar 1971 that (I) (we) last saw the deceased alive on 5 Mar 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Harold P. Biehl MD | | 23B. DATE SIGNED 6 Mar 71 | | |
| 23C. PHYSICIAN'S NAME (Type) Harold P. Biehl, MD. | | 23D. ADDRESS Keswick Home, 700-W-40th, St. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-9-1971 | | |
| 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge | | 24D. LOCATION (City, town, or county) (State) Pikesville, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, MD. | | |
| 25C. FUNERAL DIRECTOR Wm. Cook-Brooks | | ADDRESS Towson, Md. 21204 | | |



FUNERAL DIRECTOR: IMPORTANT

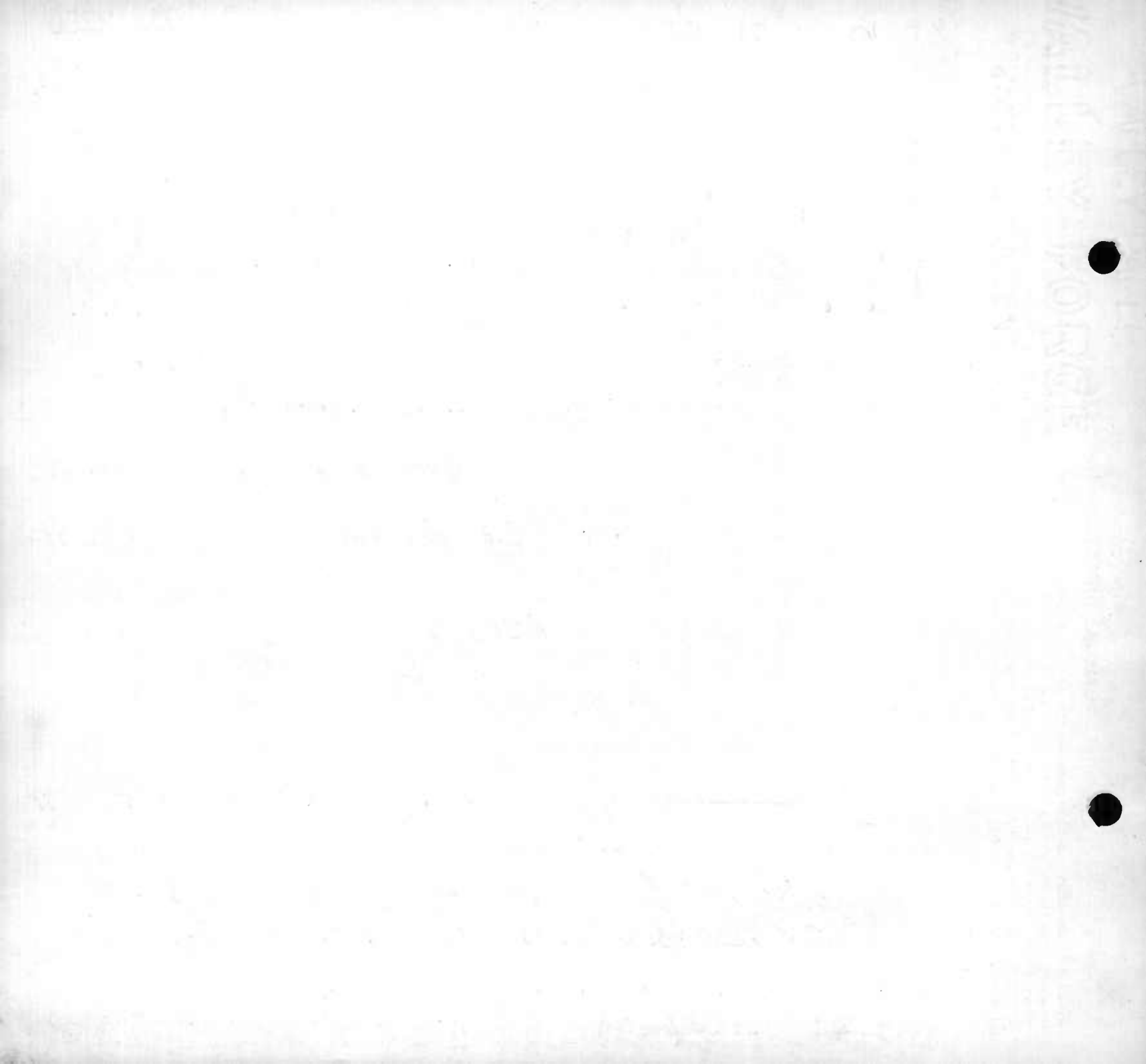
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2278</u> | |
|---|--|---|--|---|--|
| S-346 71 2278 | | 71 2278 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>John Thorpe Staylor, Sr</u> | | 2. DATE AND HOUR OF DEATH <u>3-5-71</u> <u>11¹⁵A</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Bolton Hill Nursing Home</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>831</u> | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>Caucasian</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 8. DATE OF BIRTH <u>Aug. 7, 1906</u> | | 9. AGE (In years last birthday) <u>64</u> | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Power Production</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Gas and Electric</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>Henry M. Staylor</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Carrie Thorpe</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>212-05-6155</u> | | 17. INFORMANT <u>Mr. J. Thorpe Staylor, Jr.</u> ADDRESS <u>1007 Timber Trail Rd. Towson, Md. 21204</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>410.9 I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CAUSE OF DEATH</u> <u>Acute myocardial infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic cardiovascular disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>sudden</u> <u>5 years.</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 1963</u> to <u>March 5 1971</u> , that (I) was last saw the deceased alive on <u>Feb. 28 1971</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) Was (did) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Alfred G. Ossman Jr. M.D.</u> | | 23B. DATE SIGNED <u>3-7-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Alfred G. Ossman, Jr., M. D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>Mar. 8, 71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> | |
| 24D. LOCATION <u>Baltimore Maryland</u> | | 24E. FUNERAL DIRECTOR <u>Wm. Cook Brooks</u> ADDRESS <u>1050 York Road Towson, Md. 21204</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>John E. Taylor</u> | | 25C. NAME OF REGISTRAR <u>John E. Taylor</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 71 2280 |
|--|------------------------------------|---|---|--|---|
| BIRTH NO. 1-200 | | 71 2280 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MATTIE VICTORIA LEWIS | | | 2. DATE AND HOUR OF DEATH March 5, 1971 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 807 Lenton Ave Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2768 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 807 Lenton Avenue | | |
| 5. SEX Female | 6. RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 12, 1888 | 9. AGE (In years last birthday) 82 yrs. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME Starkie Thompson | | |
| 14. MOTHER'S MAIDEN NAME Brickle | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ----- | | |
| 16. SOCIAL SECURITY NO. 215-10-3878B | | | 17. INFORMANT ADDRESS Mr. Major B. Lewis, Same as # 4 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF: (B) CA Rectum DUE TO, OR AS A CONSEQUENCE OF: (C) ----- | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months 1 1/2 yrs | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD | | | 4 yrs | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location) | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1 Nov 1955 to March 5 1971, that (I) (we) last saw the deceased alive on 27 FEB. 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Attended by | | | 23B. DATE SIGNED 3-6-71 | | 23C. PHYSICIAN'S NAME (Type) S. J. VENABLE, JR. M.D. |
| 23D. ADDRESS 7215 YORK RD, BALTIMORE MD | | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | |
| 24B. DATE 3-8-1971 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

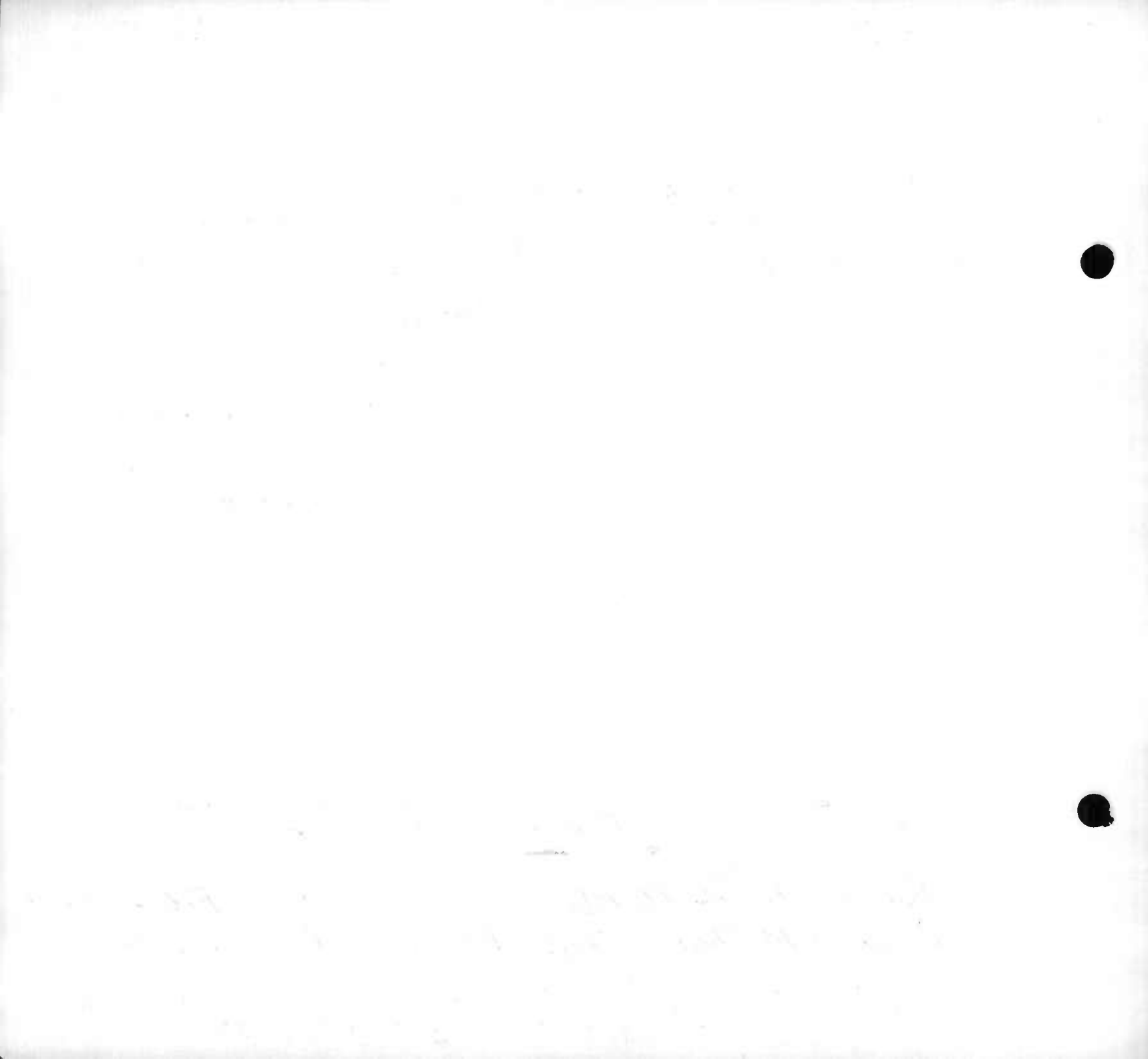
| BIRTH NO. BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 58-51-71-2281 | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Dorsey Boy Lela | | 2. DATE AND HOUR OF DEATH February 22, 1971 7:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 21224 4940 Eastern Avenue Baltimore, Maryland | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1606 | |
| 5. SEX Male 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | E. STREET AND NUMBER 2714 Harlen Avenue 21216 | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 2-22-71 9. AGE (In years last birthday) 2 If Under 1 Yr. Months Days If Under 24 Hrs. Min. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME Lela K. Dorsey | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT BCH: Records 4940 Eastern Avenue Baltimore, Maryland 21224 | | ADDRESS | |
| 18. 776.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE prematurity DUE TO, OR AS A CONSEQUENCE OF: (B) respiration distress 2 hrs. (C) meconium aspiration II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). D flank mass | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Feb 22 5⁴⁰ am 1971 to Feb 22 7⁴⁵ am 1971 that (1) (we) last saw the deceased alive on Feb 22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Dr. Tripp MD | | 23B. DATE SIGNED 2/22/71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Tripp MD | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 2-23-71 | |
| 24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, R.D. | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |
| HOSPITAL DISPOSAL | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

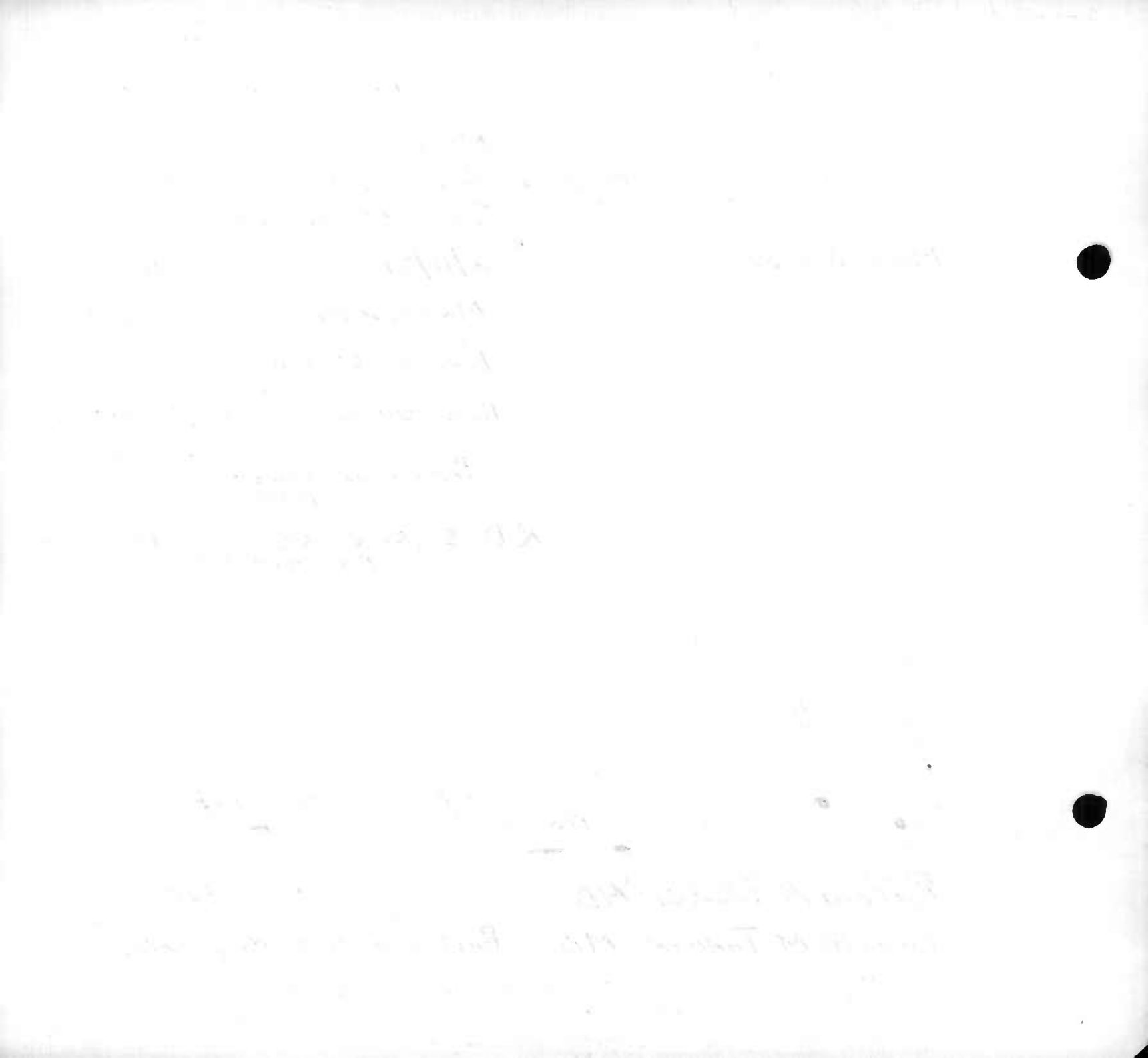
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2282 | |
|--|------------------|---|--|---|--|
| BIRTH NO. 71-03171 | | | | 71 2282 | |
| 1. NAME OF DECEASED (Type or Print) BABY GIRL Thomas (Shirley) | | | | 2. DATE AND HOUR OF DEATH Feb 28, 1971 1 900 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224 | | | | A. STATE Maryland B. COUNTY 804 | |
| C. CITY OR TOWN Baltimore | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 2243 E. Biddle | | | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/20/71 | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME Shirley Thomas | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT BCH RECORDS: | | | ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224 | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 DAYS | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity - Dysmaturity | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (if) (this hospital) attended the deceased from Feb 20 1971 to Feb 28 1971 that (we) last saw the deceased alive on Feb 28 1971 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard M. Thaller MD | | | | 23B. DATE SIGNED Feb 28, 1971 | |
| 23C. PHYSICIAN'S NAME (Type) Richard M Thaller MD | | | | 23D. ADDRESS Baltimore City Hospitals | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3-1-71 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals | |
| 24D. LOCATION Baltimore, Maryland | | 24E. CITY, TOWN, or county 21224 | | 24F. STATE | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR 2 HOSPITAL DISPOSAL | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

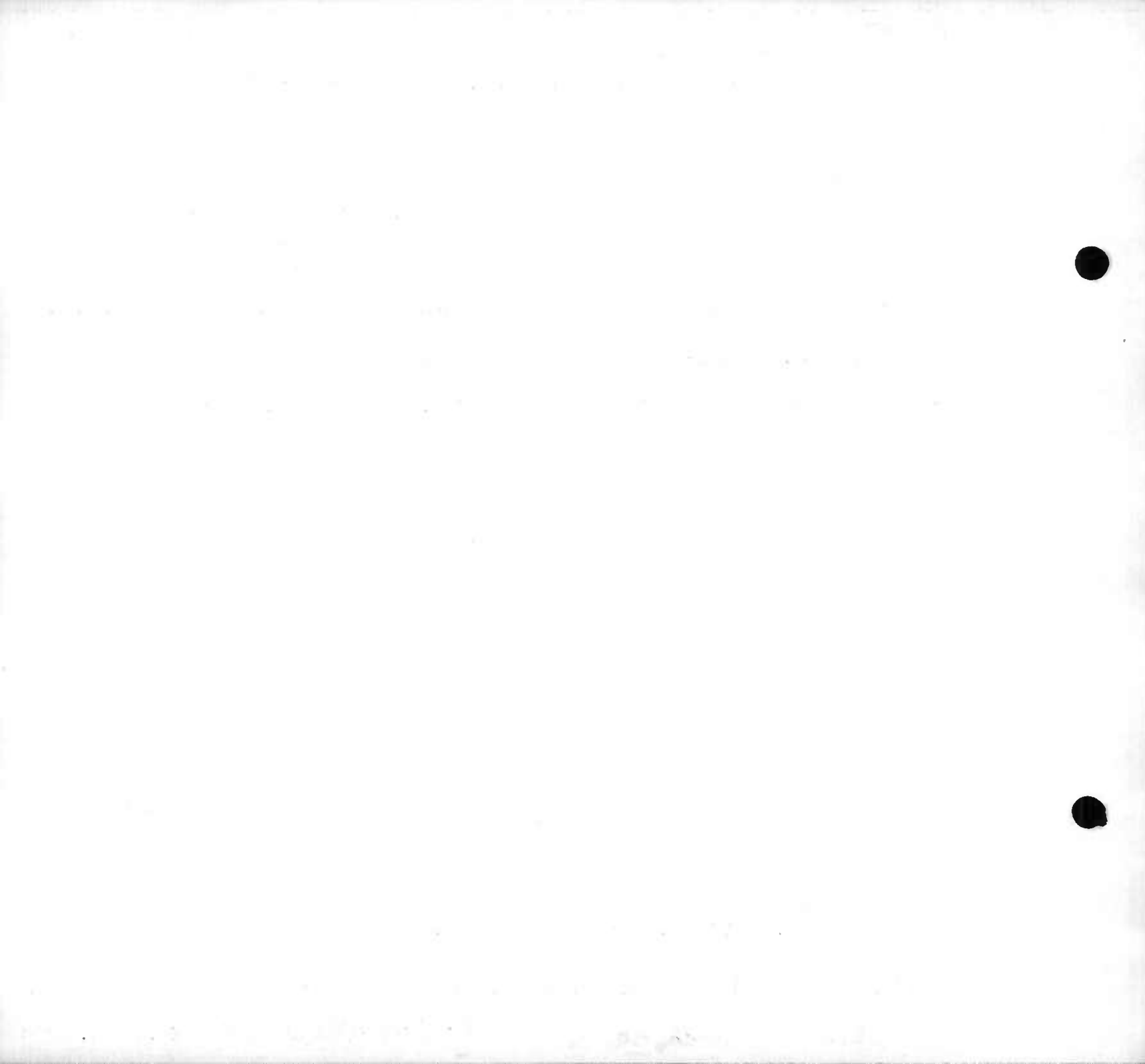
| | | | | | |
|--|--|---|---|---|--|
| BIRTH NO. <u>W-325</u> <u>71-0269271</u> <u>2283</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>71</u> <u>2283</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>BABY BOY WATKINS</u> | | | 2. DATE AND HOUR OF DEATH <u>Feb 26, 1971</u> <u>9:31 P.</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> 4940 Eastern Avenue Baltimore, Maryland 21224 | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>Male</u> | | | 6. RACE <u>NEGRO</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>2/11/71</u> |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | | 9. AGE (In years last birthday) <u>15</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME <u>Renee WATKINS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>RECH. RECORDS, Baltimore, Maryland - 212247.</u> |
| 18. <u>486X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PNEUMONIA, BILAT.?</u> DUE TO, OR AS A CONSEQUENCE OF: <u>PROBABLE</u> (B) <u>R.D.S. SEVERE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>PREMATURITY</u> (C) _____ | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>2/11</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from <u>2/11</u> 19 <u>71</u> to <u>Feb 26</u> 19 <u>71</u> that (we) last saw the deceased alive on <u>FEB 26</u> 19 <u>71</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Richard M. Thaller MD</u> | | | | 23B. DATE SIGNED <u>Feb 26, 1971</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>RICHARD M. THALLER MD</u> | | | | 23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u> 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>3-1-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Baltimore City Hospitals</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 24E. LOCATION (City, town, or county) (State) <u>21224</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert J. Smith</u> | | 25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | REG. NO. 71 2284 |
|--|---------------------|---|--|---|---|---|
| BIRTH NO. C-245 | | 71 2284 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Robert Edward Coughlan, Jr. | | | 2. DATE AND HOUR OF DEATH March 5, 1971 15:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1307 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 711 W. University Parkway | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-3-1899 | 9. AGE (In years last birthday) 72 | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney Lord-Whip-Coughlan-Green | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | | |
| 13. FATHER'S NAME Robert E. Coughlan | | | 14. MOTHER'S MAIDEN NAME Nellie Wheatley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI | | | 16. SOCIAL SECURITY NO. 3-03-0929A | | | |
| 17. INFORMANT Mrs. Margaret W. Coughlan | | | ADDRESS Same | | | |
| 18. CAUSE OF DEATH | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.31 | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (B) coronary heart disease DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | | | |
| II | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 27 1967 to present 19 that (I) (we) last saw the deceased alive on 15th of September 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE P.D. Wagley | | | | 23B. DATE SIGNED 3-8-71 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Philip F. Wagley | | | | 23D. ADDRESS 9 E. Chase Street | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | |
| 24D. LOCATION (City, town, or county) (State) Pikesville, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | | |
| 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | 71 2285 | 71 2285 |
|---|---------------------|---|--|---|--|
| 71 2285 CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>Edna Riddle (Edna D. Riddle)</i> | | 2. DATE AND HOUR OF DEATH <i>12 AM 3-6-71</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Good Samaritan Hospital</i> <i>45</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> | |
| C. CITY OR TOWN <i>BALTIMORE</i> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| E. STREET AND NUMBER <i>333 LANBOURNE RD.</i> <i>21204</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>03/29/97</i> | 9. AGE (In years last birthday) <i>73</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i> | | 11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | | | | |
| 13. FATHER'S NAME <i>Charles F. Dorsey</i> | | 14. MOTHER'S MAIDEN NAME <i>ANNIE E. GIVVINES</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>214-22-7860</i> | | 17. INFORMANT <i>MRS. THOMAS L. HURST</i> <i>309 TUNBRIDGE RD.</i> <i>21212</i> | |
| 18. <i>199.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory, cardiac arrest</i> <i>Unmed</i> | | (B) <i>Unspread Cancer</i> DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <i>3/6</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/22</i> 19 <i>70</i> to <i>3/6</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>3/6</i> 19 <i>71</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>William A. Carter MD</i> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>3-6-71</i> | |
| 23C. PHYSICIAN'S NAME (Typed) <i>WILLIAM A. CARTER</i> | | 23D. ADDRESS <i>Good Samaritan Hosp</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-9-1971</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore,</i> | | (State) <i>Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Talley</i> | | 25C. FUNERAL DIRECTOR <i>H. W. Jenkins & Sons Co.</i> <i>2405 York Road Balto., Md. 21212</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2286</u> | |
|---|------------------|--|--|---|--|
| BIRTH NO. <u>B-626 71 2286</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Rose Taylor Bricker</u> | | | 2. DATE AND HOUR OF DEATH <u>Mar. 5, 1971</u> <u>9:50</u> A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 4505 Arabia Ave.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2702</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4505 Arabia Ave.</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-19-1892</u> | 9. AGE (In years last birthday) <u>78</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Government</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Fort Meade</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>Thomas H. Taylor, Sr.</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Anna M. Bray</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>212-09-9217</u> | | | 17. INFORMANT <u>Miss Ruth T. Bricker</u> ADDRESS <u>Same</u> | | |
| 18. <u>15321</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u> | | | (A) IMMEDIATE CAUSE <u>Carcinoma, metastatic</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Carcinoma of sigmoid colon</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>2 years</u> | | |
| 19A. DATE OF OPERATION <u>Oct. 26, 1970</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Mass in abdomen</u> | | |
| 20A. AUTOPSY? (Yes or No) <u>No</u> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 21, 1952</u> to <u>March 5, 1971</u> that (I) (we) last saw the deceased alive on <u>March 4, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>John Tilden Howard, M.D.</u> | | | 23B. DATE SIGNED <u>March 6, 1971</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. John T. Howard</u> | | | 23D. ADDRESS <u>12 E. Eager Street</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>3-8-1971</u> | | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u> | | |
| 25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> | | | ADDRESS <u>4905 York Road Balto., Md. 21212</u> | | |



1

S-643 71 2287 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 2287

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MARTHA/SCARLETT | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 3 4 1971 3 p M. | |
| 6. SEX female | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 3/20/1898 | | 10. AGE (In years lost birthday) 72 | |
| 11. BIRTHPLACE (State or foreign country) Philadelphia, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 14B. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 117-20-6276 | |
| 18. INFORMANT Mrs. Martha J. Shaffer | | ADDRESS 21236 4701 Ebenezer Rd. | |
| 19. 4/24 CAUSE OF DEATH Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Isidore Mihalakis, MD. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 3/5/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial | | 24B. DATE 3/8/71 | |
| 24C. NAME of CEMETERY or CREMATORY Hillside | | 24D. LOCATION (City, town, or county) (State) Philadelphia, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | |
| 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. Balto., Md. 21212 | |

VS 151-REV. 1/1/68

WALTER

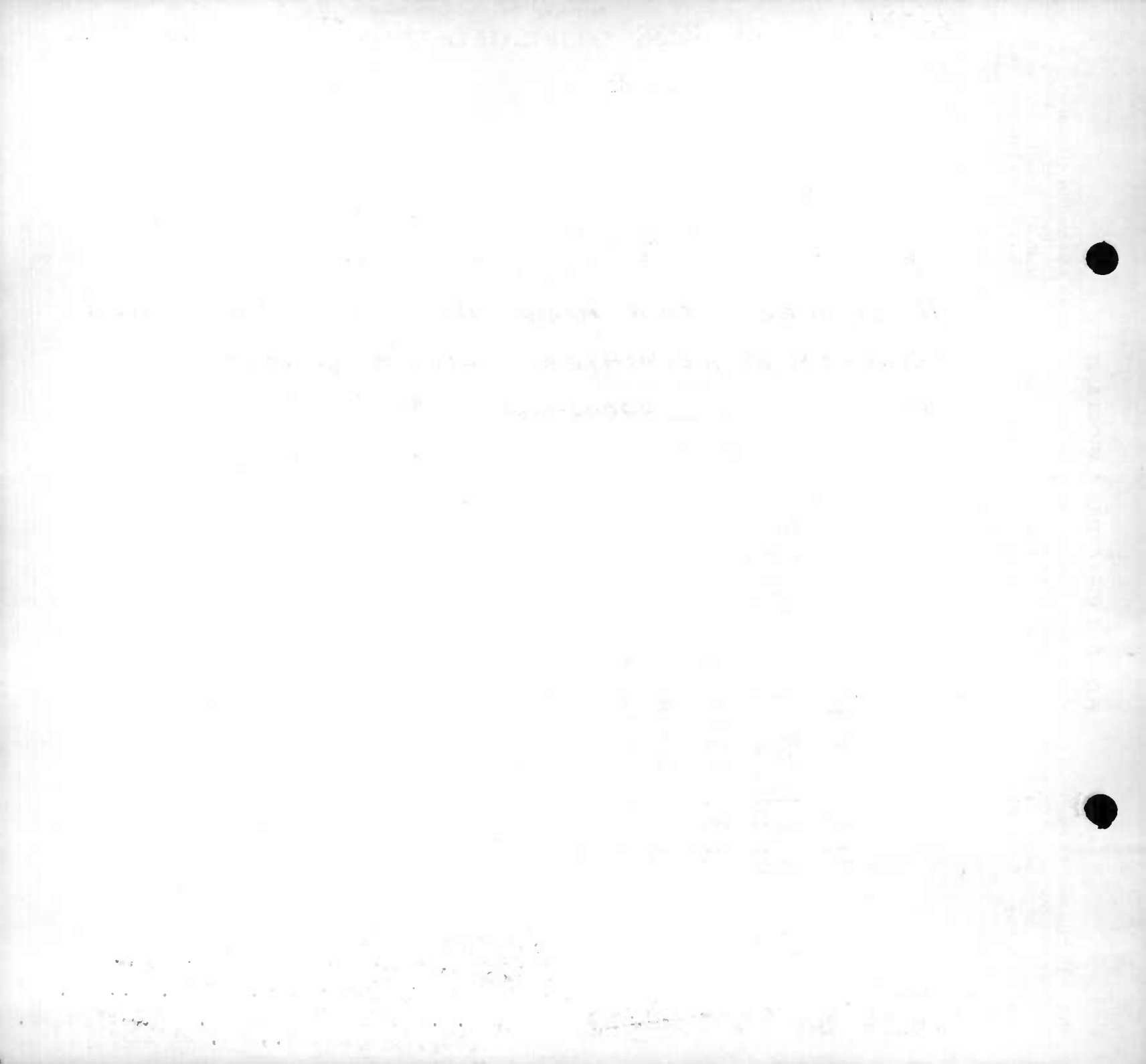
PROCTOR

W. Proctor

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|---|--|---|--|--|--|----------------------------------|--|
| 71 2288 CERTIFICATE OF DEATH | | | | | Registered No. 71 2288 | | | | |
| 1. NAME OF DECEASED (Type or Print) MYRTLE N. LANE | | | | | 2. DATE AND HOUR OF DEATH MARCH 4, 1971 11:00 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md. GEN HOSP | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY 5300 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 315 STANMORE RD | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) | | 8. DATE OF BIRTH MAY 22, 1897 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME FREDERICK W. NEUMAYER | | | | 14. MOTHER'S MAIDEN NAME LILLIE V. SCOTT | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 220-12-4268 | | 17. INFORMANT ADDRESS WILLIAM C. LANE, JR. 315 Stanmore Rd. | | | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.) Acute Myocardial Infarction Atherosclerotic Coronary Disease | | | | (A) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | | | |
| | | | | (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 4, 1971 to MARCH 4, 1971 , that (II) (we) last saw the deceased alive on MARCH 4, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Bayan B. Elma, M.D. | | | | | 23B. DATE SIGNED MARCH 4, 1971 | | 23C. PHYSICIAN'S NAME (Type) BAYANI B. ELMA, M.D. | | |
| 23D. ADDRESS Md. GEN HOSP BALTO. MD. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/71 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood | | 24D. LOCATION (City, town, or county) (State) Parkville, Balto. Co., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, R.D. | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2289 4 | |
| BIRTH NO. 4-536 71 2289 71-03384 | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy Henderson | | 2. DATE AND HOUR OF DEATH 3/2/71 10 05 AM. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 602 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home and Hospital 100 N Broadway Baltimore MD 21231 | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 100 N Broadway street | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/2/71 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY None | 9. AGE (in years last birthday) One FEW |
| 11. BIRTHPLACE (State or foreign country) Church Home Hospital | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JERRY HENDERSON | | 14. MOTHER'S MAIDEN NAME C. Poria | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Dr. A. Boyd | | ADDRESS Church Home Hospital | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 769.1 I CAUSE OF DEATH Clinical impression possible Intracranial Hemorrhage due to, or as a consequence of, extreme molding of skull bones during delivery and prematurity. Premature Rupture membrane Approximate interval between onset and death within 1 hour | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DATE OF OPERATION None | | 20A. AUTOPSY? (Yes or No) None | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None | | 21D. TIME OF INJURY (Approx.) None | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? None | |
| 22. I certify that (1) (this hospital) attended the deceased from 3/2 19 71 to 3/2 19 71 and that (2) (we) last saw the deceased alive on 3/2 19 71 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Mona S. Belinic | | 23B. DATE SIGNED 3/2/1971 | |
| 23C. PHYSICIAN'S NAME (Type) MONA S. BELINIC | | 23D. ADDRESS Church Home Hospital, Nursery Dept. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 3-4-71 | | 24B. DATE 3-4-71 | |
| 24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL | | 24D. LOCATION MORTUARY SERVICE - BCHD | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | | 25D. ADDRESS MORTUARY SERVICE - BCHD | |

122 N. Port St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2290 4 | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED <small>(Type or Print)</small> X-6/6 71 2290 71-03394 BABY GIRL YARBER | | 2. DATE AND HOUR OF DEATH March 1, 1971 3:50 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home and Hospital 35 | | 4. USUAL RESIDENCE <small>(Where deceased lived, If institution: residence before admission)</small> A. STATE B. COUNTY Maryland Baltimore C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3411 E. Baltimore Street 21224 | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-1-71 | | 9. AGE <small>(In years last birthday)</small> 18 |
| 10A. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE <small>(State or foreign country)</small> Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Edward Yarber | | | |
| 14. MOTHER'S MAIDEN NAME Georgeanna Ries | | 15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</small> </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE PREMATURITY <small>DUE TO, OR AS A CONSEQUENCE OF:</small> (B) PREMATURE RUPTURE OF MEMBRANES <small>DUE TO, OR AS A CONSEQUENCE OF:</small> (C) </div> <div style="width: 10%; text-align: right;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 MIN. </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? <small>(Yes or No)</small> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <small>(notify medical examiner)</small> <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small> | | 21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small> | | | |
| 21D. TIME OF INJURY <small>(Month) (Day) (Year) (Hour)</small> <small>(APPROX.)</small> | | 21E. INJURY OCCURRED <small>While At Work</small> <input type="checkbox"/> <small>Nat While At Work</small> <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 1 1971 to MARCH 1 1971 , that (I) (we) last saw the deceased alive on MARCH 1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. William Dorman Jr M.D. | | | | 23B. DATE SIGNED 3-1-71 | |
| 23C. PHYSICIAN'S NAME <small>(Type)</small> Dr. J. W. Dorman, Jr. | | | | 23D. ADDRESS 3101 St. Paul St. | |
| 24A. BURIAL CREMATION, REMOVAL <small>(Specify)</small> | | 24B. DATE 3-4-71 | | 24C. NAME OF CEMETERY OR PLACE OF INTERMENT ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert E. Faber M.D. | | | |
| JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BOARD | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to a funeral home. It must also be approved by a medical examiner if death occurred in a hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-345 71 2291 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2291 | |
|--|--|---|--|--|---|
| BIRTH NO. | | | REG. NO. | | |
| 1. NAME OF DECEASED (Type or Print) STOLLENWERCK MR FRANK | | | 2. DATE AND HOUR OF DEATH MARCH 5 1971 4:35 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL 35 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1203 | | |
| 5. SEX M | | | 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 03 24-83 | |
| 13. FATHER'S NAME FRANK STOLLENWERCK | | 14. MOTHER'S MAIDEN NAME EMMA CALHOUN | | 9. AGE (In years last birthday) 87 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 557 34011 | | 11. BIRTHPLACE (State or foreign country) ALA | |
| 17. INFORMANT | | ADDRESS | | 12. CITIZEN OF WHAT COUNTRY? A M E R I C A | |
| 18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ATHEROSCLEROSIS. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5.6 day | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). INTERSTINAL OBSTRUCTION | | | | | |
| 19A. DATE OF OPERATION FEB 16 1971 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTERSTINAL OBSTRUCTION | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/15 19 71 to 3/5 19 71 that (I) (we) last saw the deceased alive on 3/4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A Mehla | | | 23B. DATE SIGNED 3/5/71 | | 23C. PHYSICIAN'S NAME (Type) A. MEHTA |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE 3-5-71 | | 24C. NAME OF CEMETERY or CREMATION ANATOMY BOARD OF MARYLAND |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8, 1971 | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

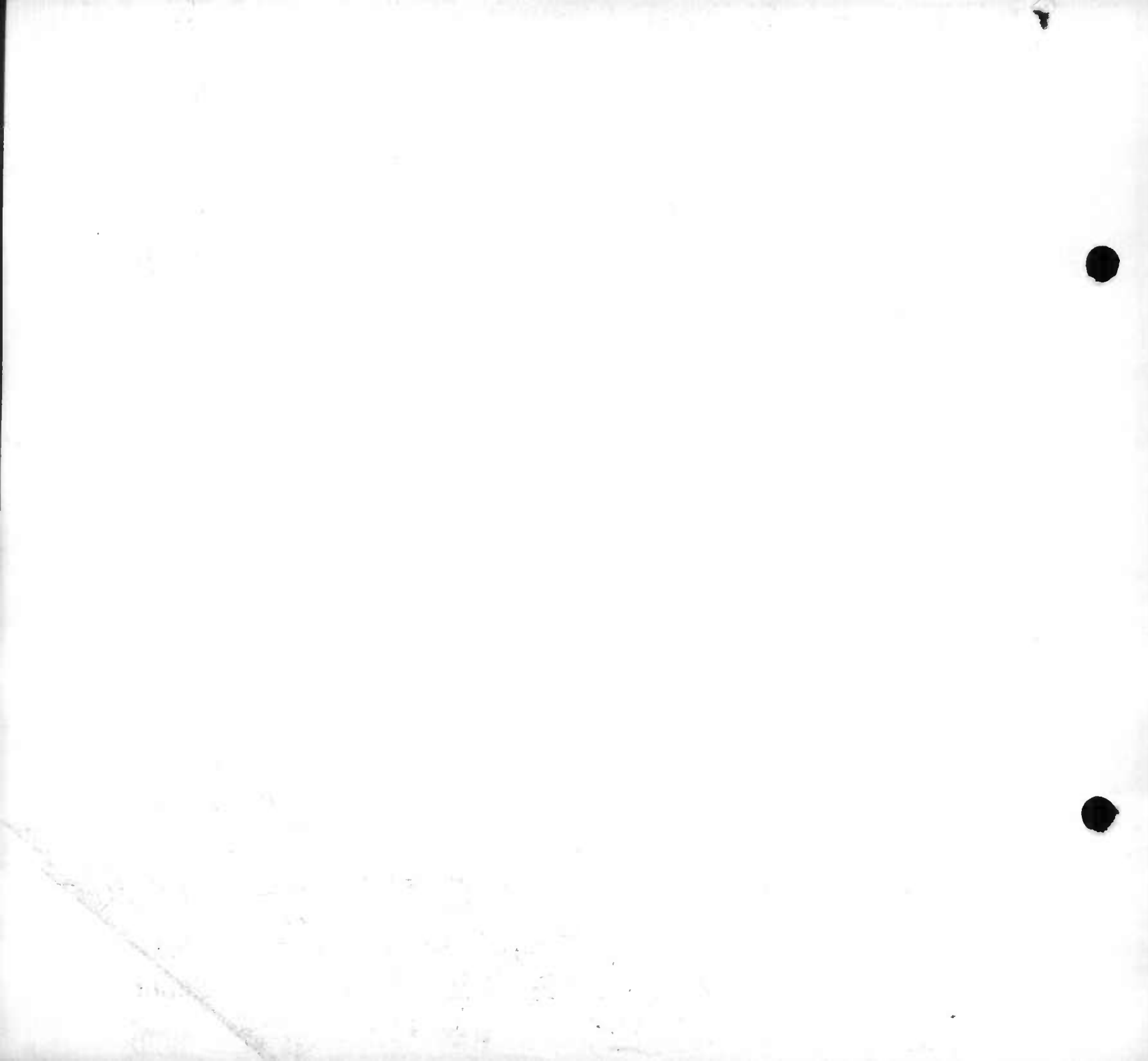
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2292 | |
|--|--|---|---|---|---|
| S-361 71 2292 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) HELEN STROBLING | | | 2. DATE AND HOUR OF DEATH 2/12/71 1:12 PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY Pr. George's | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY | | | C. CITY OR TOWN District Heights | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX F | | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 9-24-18 | 9. AGE (in years last birthday) 52 |
| 11. BIRTHPLACE (State or foreign country) D.C. | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME WILLIAM | |
| 14. MOTHER'S MAIDEN NAME BLANCHE | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT SPRING GROVE ST. Hosp. | | ADDRESS | | | |
| 18. I 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 3/1/26 71 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN METASTASES | | 20A. AUTOPSY? (Yes or No) YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-18 19 71 to 2-11 19 71 that (I) (we) last saw the deceased alive on 2-11 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David M. Cook | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) DEGREE |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE 2-26-71 | | 24C. NAME OF CEMETERY ANNAHON BOARD OF MARYLAND AND |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | | 25B. NAME OF REGISTRAR John H. ... | | |

102576

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|---|--|
| <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p> | | <p>REG. NO. <u>71 2293</u></p> | |
| <p>BIRTH NO. <u>71-02166</u></p> | | <p>2. DATE AND HOUR OF DEATH <u>12 Feb, 71 1230 A.M.</u></p> | |
| <p>1. NAME OF DECEASED (Type or Print) <u>BABY JOHNSON</u></p> | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>SPELMAN RD 2562</u></p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>380 OF MD. HOSPITAL</u></p> | | <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | |
| <p>5. SEX <u>M</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | | <p>8. DATE OF BIRTH <u>2/4/71</u> 9. AGE (In years last birthday) <u>0 2 0</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p> | |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> | | <p>11. BIRTHPLACE (State or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p> | |
| <p>13. FATHER'S NAME <u>MARTIN TRUESDALE</u></p> | | <p>14. MOTHER'S MAIDEN NAME <u>OLIVIA JOHNSON</u></p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> | | <p>16. SOCIAL SECURITY NO. <u>HOSPITAL RECORD</u></p> | |
| <p>18. <u>776-11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HYALINE MEMBRANE DISEASE</u></p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 DAYS</u></p> | |
| <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PREMATURITY</u></p> | | <p><u>10 DAYS</u></p> | |
| <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | | |
| <p>19A. DATE OF OPERATION <u>2/12/71</u></p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NECROPSY</u></p> | |
| <p>20A. AUTOPSY? (Yes or No) <u>YES</u></p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p> | |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that <u>Dr.</u> (this hospital) attended the deceased from <u>2/4</u> 19 <u>71</u> to <u>2/12</u> 19 <u>71</u> that <u>he</u> (we) last saw the deceased alive on <u>2/12/71</u> 19 <u>71</u> and that <u>in</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (We) <u>did</u> (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE <u>John V. Payne MD</u></p> | | <p>23B. DATE SIGNED <u>13/2/71</u></p> | |
| <p>23C. PHYSICIAN'S NAME (Type) <u>JOHN V. PAYNE</u></p> | | <p>23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL JOHNS HOPKINS MEDICAL SCHOOL</u></p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>2-26-71</u></p> | | <p>24B. DATE <u>2-26-71</u></p> | |
| <p>24C. NAME OF CEMETERY <u>JOHNS HOPKINS MEDICAL SCHOOL</u></p> | | <p>24D. LOCATION (City, town, or county) (State)</p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u></p> | | <p>25B. NAME OF REGISTRAR <u>John V. Payne</u></p> | |
| <p>25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHO</u></p> | | <p>ADDRESS</p> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|------------------|--|---------------------------------|
| <div style="display: flex; justify-content: space-between;"> 7-630 71 2294 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> REG. NO. 71 2294 CERTIFICATE OF DEATH </div> | | | |
| BIRTH NO. <u>71-03539</u> 1. NAME OF DECEASED (Type or Print) <u>BABY GIRL FORD</u> | | 2. DATE AND HOUR OF DEATH <u>11:30 PM 2/22/71</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>NEWBORN Md</u> B. COUNTY <u>1403</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2014 Madison Ave</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/22/71</u> |
| 9. AGE (in years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>BERNARD FAISON</u> | | 14. MOTHER'S MAIDEN NAME <u>DEBORAH FORD</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | |
| 18. <u>7-26-71 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (A) IMMEDIATE CAUSE <u>PULMONARY IMMATUREITY</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PULMONARY IMMATUREITY</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>PREMATURITY</u> | | | |
| 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased, from <u>5:34 2/22 1971</u> to <u>11:30 2/22 1971</u> that (I) (we) last saw the deceased alive on <u>2/22/71</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Kenneth Hoffman</u> M.D. DEGREE | | 23B. DATE SIGNED <u>2/22/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Kenneth Hoffman</u> M.D. DEGREE | | 23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>2-26-71</u> | | 24B. DATE <u>2-26-71</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant. Death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| L-200 | | 71 2295 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2295 | |
|---|-------------------------|---|------------------------------------|---|-----------------------------|---|--|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Robert W. Lewis</u> | | | | 2. DATE AND HOUR OF DEATH <u>March 4, 1971 3:45 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND General Hospital</u> <u>48</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore County</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3214 Milford Ave.</u> <u>2802</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/20/97</u> | 9. AGE (In years last birthday) <u>73</u> | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX Dept Head-Internal Rev.</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Owen Lewis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Smith</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>XXXXXX WW1 Navy</u> | | | | 16. SOCIAL SECURITY NO. <u>215-34-7619</u> | | 17. INFORMANT <u>Elsie L. Lewis-3214 Milford Avenue 21207</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>Hypovolemic shock</u> <u>Adeno CARCINOMA of Stomach</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Ulceration of tumor & Bleeding</u> (C) <u>Adeno CARCINOMA of Stomach</u> <u>Carcinomatosis</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>6 months</u> <u>1 week</u> <u>6 months</u> | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Carcinomatosis</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>10-7-70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Adeno CARCINOMA OF Stomach</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>No</u> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>No</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>No</u> | | 21F. HOW DID INJURY OCCUR? <u>No</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 3</u> 19 <u>71</u> to <u>March 4</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>March 4</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Thomas G. Abbott</u> | | | | 23B. DATE SIGNED <u>3-5-71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Thomas G. Abbott</u> | | | | 23D. ADDRESS <u>4509 Liberty Heights Ave</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-6-1971</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Armstrong Funeral Chapel</u> | | ADDRESS <u>4600 Liberty Hts</u> | |

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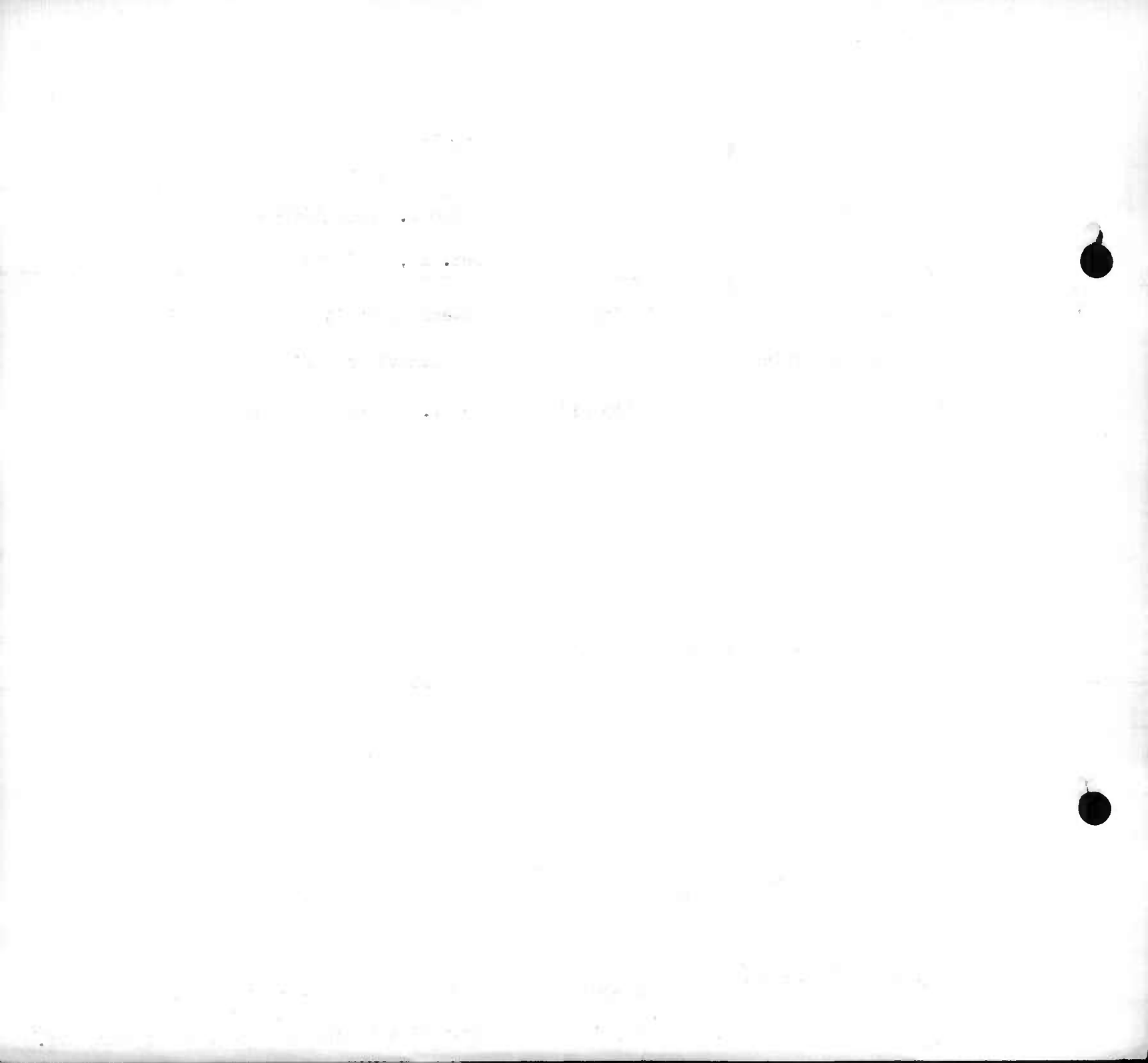
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2296 | | X | | 71 2296 | |
|--|---------------------|---|--|---|--|---|--|--|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) STEVEN SOVICH | | | | 2. DATE AND HOUR OF DEATH March 5, 1971 2:10 P.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 91 Montebello State Hospital Baltimore, Md. 21218 | | | | A. STATE Maryland | | B. COUNTY Baltimore | | 5.300 | |
| | | | | C. CITY OR TOWN Essex 21221 | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER 700 S. Marlyn Avenue | | | | | |
| 5. SEX Male | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 13, 1893 | | 9. AGE (in years last birthday) 77 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger | | | | 10B. KIND OF BUSINESS OR INDUSTRY Shipping | | 11. BIRTHPLACE (State or foreign country) Czechoslovakia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Matteo Sovich | | | | 14. MOTHER'S MAIDEN NAME Genevieve Rubinich | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 153 016949 | | 17. INFORMANT Mary E. Sovich | | ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II | | | | CAUSE OF DEATH Bronchogenic Carcinoma of Lung with metastasis. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years | |
| 19A. DATE OF OPERATION 6 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/3 19 71 to 3/5 19 71 that (I) (we) last saw the deceased alive on 3/5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Kiao-Siong Tan, M.D. | | | | 23B. DATE SIGNED 3/5/71 | | 23C. PHYSICIAN'S NAME (Type) KIAO-SIONG TAN, M.D. | | 23D. ADDRESS Montebello State Hospital, Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 3/8/71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor, R.D. | | 25C. FUNERAL DIRECTOR Brudzinski Funeral Home | | | |
| | | | | | | ADDRESS 1407 Eastern Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2297 | |
|---|-------------------------|---|---|--|--|
| S-363 | | | | 71 2297 | |
| BIRTH NO. | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>Charles B. Stewart.</i> | | | | 2. DATE AND HOUR OF DEATH <i>3-4-71 7:40 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>48 Maryland General Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Woodlawn</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>5521 Clifton Avenue 21207</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3-4-1883</i> | 9. AGE (in years last birthday) <i>88</i> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Engineer</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Kernans Hospital</i> | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 13. FATHER'S NAME <i>Charles Stewart</i> | | |
| 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | |
| 16. SOCIAL SECURITY NO. <i>216-03-9944</i> | | | 17. INFORMANT ADDRESS <i>Mrs. Helen M. Stewart, 5521 Clifton Ave. 21207</i> | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Metastatic Carcinoma</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of larynx</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <i>3-4-71</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <i>XXXXX</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2-24</i> 19 <i>71</i> to <i>3-4</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>3-4</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Alejandro Segueira</i> | | | | 23B. DATE SIGNED <i>3-4-71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Alejandro Segueira</i> | | | | 23D. ADDRESS <i>Maryland General Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-8-1971</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i> | |
| 24D. LOCATION <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 9 1971</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i> | | | |
| 25D. ADDRESS <i>4107 Wilkens Ave. 21229</i> | | | | | |

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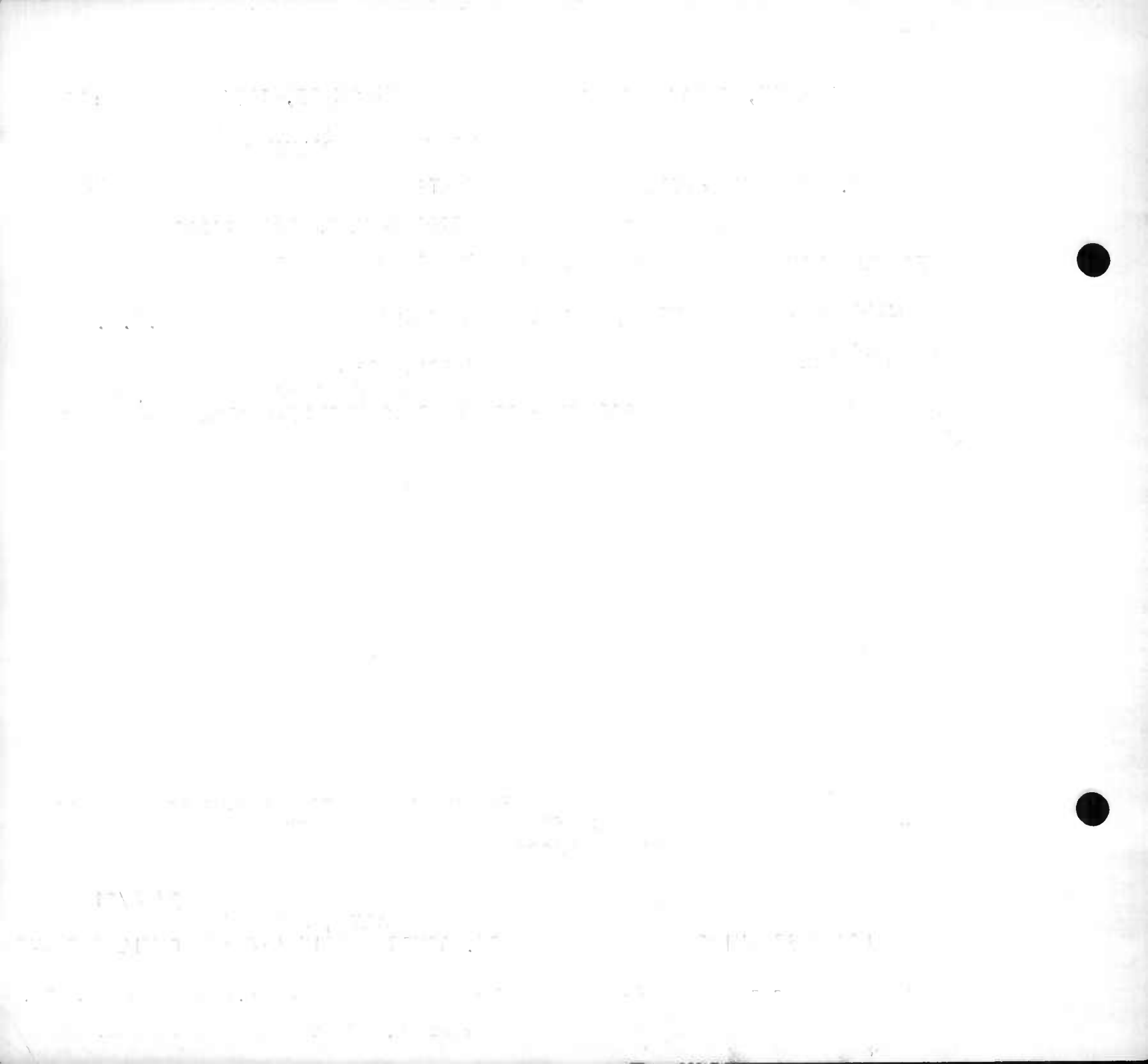
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

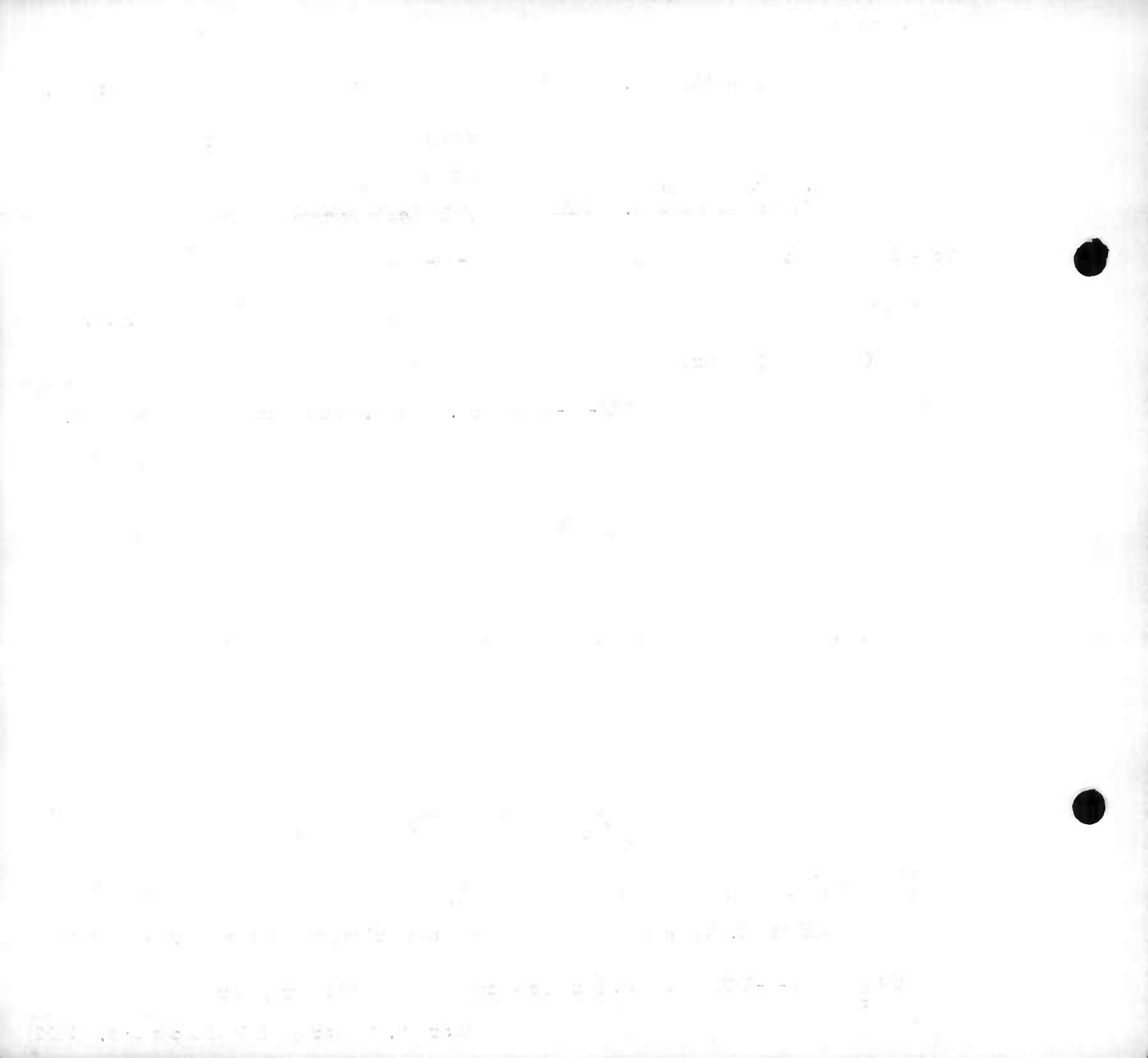
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2298 | |
|--|--|--|--|---|--|
| B-420 71 2298 BIRTH NO. 1. NAME OF DECEASED (Type or Print) BULLOCK, GLADYS AMELIA | | 2. DATE AND HOUR OF DEATH MARCH 05, 1971 8:15A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN XXXXXXXXXX ARBUTUS D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5501 OAKLAND ROAD 21227 | | | |
| 5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 01 13 04 9. AGE (in years last birthday) 67 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BUYER | | 10B. KIND OF BUSINESS OR INDUSTRY STORE, Woolworth | | 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ROBERT FILLMORE | | 14. MOTHER'S MAIDEN NAME MAGGIE ACTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213 03 9438 | | 17. INFORMANT WILKENS AVE BALTO MD 21229 ADDRESS 3 ST AGNES HOSPITAL RECORDS CATON & | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). </div> <div style="width: 15%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 80%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hodgkin disease </div> <div style="width: 15%;"> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: </div> </div> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

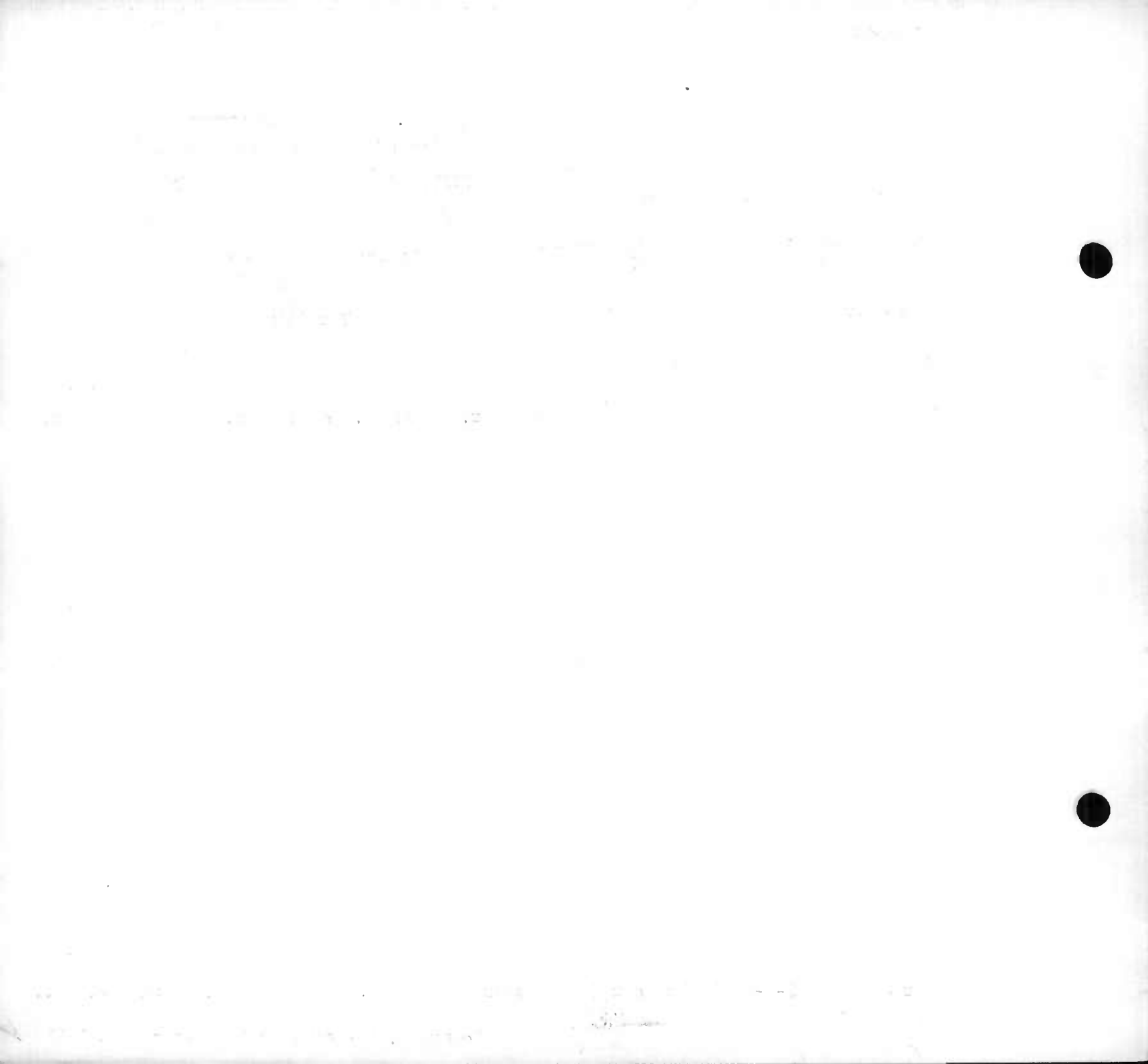
| BALTIMORE CITY HEALTH DEPARTMENT | | | | X REG. NO. 71 2299 | |
|---|--|---|--|---|--|
| 5-530 71 2299 | | BIRTH NO. | | 71 2299 | |
| 1. NAME OF DECEASED (Type or Print) | | CHARLOTTE J. SCHMIDT | | 2. DATE AND HOUR OF DEATH March 4, 1971 3:30 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE & COUNTY | | Maryland Baltimore 5300 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton & Wilkens Ave. 21229 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 11-13-1898 | | 9. AGE (in years last birthday) 72 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME (Unknown (Derr | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-09-8298 | | 17. INFORMANT Mrs. June M. Bartschert, 5015 Leeds Ave. ADDRESS 21227 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH Cerebrovascular hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Hypertensive CVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19 65 to March 4 19 71 that (I) (we) last saw the deceased alive on Feb 8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (No) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Herbert J. Levickas | | 23B. DATE SIGNED 3/5/71 | | 23C. ADDRESS 5404 East Drive, Baltimore, Maryland 21227 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-1971 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. NAME of REGISTRAR | | 24F. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------|---|------------------------------------|---|---|
| H-322 71 2300 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | 71 2300 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) CORA L. HODGES | | 2. DATE AND HOUR OF DEATH 3/4/71 5:35 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH HOSP. 3001 S. HANOVER ST. | | A. STATE MD. B. COUNTY BALTIMORE | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN LANSOWNE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 2213 Smith Dr. | | | |
| 5. SEX F | 6. RACE Caw | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-14-92 | 9. AGE (in years last birthday) 78 | 10. If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) XXXX Virginia | |
| 13. FATHER'S NAME L. Morgan Petty (dec) | | 14. MOTHER'S MAIDEN NAME Lucy M^e Allister (dec) | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. WD 27603 | | 17. INFORMANT ADDRESS Mr. Robert C. Hodges, Jr. 2221 Gaylawn Dr. 21227 | |
| 18. 2047 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH !This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. | | MYOCARDIAL INFARCTION | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: LEUKEMIA, LYMPHOCYTIC | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White Al <input type="checkbox"/> Not White Al <input type="checkbox"/> Work <input type="checkbox"/> Al Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/10 19 71 to 3/4 19 71 that (I) (we) first saw the deceased alive on 3/4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Martin Shuman M.D. | | | | 23B. DATE SIGNED 3/4/71 | |
| 23C. PHYSICIAN'S NAME (Type) MARTIN J. SHUMAN M.D. | | 23D. ADDRESS So. Balto Gen Hosp 3001 S. Hanover St. Balto Md 21208 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3-8-1971 | | Meadowridge Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |



BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MILDRED M. HESS

2. DATE
OF
DEATHKnown ☐Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 SOUTH BALTO. GENERAL HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

March 4, 1971

9:30 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2534

6. SEX

Female

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

4-29-1905

10. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months | Days | Hours | Min.

E. STREET AND NUMBER

1 Washburn Avenue

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Holland

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Betty Ball

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Mrs. Joan Anderson

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Bronchopneumonia with abscess formation

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Cerebral Infarction

DUE TO, OR AS A CONSEQUENCE OF:

(C) Arteriosclerotic cardiovascular disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/5/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-8-1971

24C. NAME of CEMETERY or CREMATORY

Little Arington Cemetery

24D. LOCATION

(City, town, or county)

(State)

Elkins, West Virginia

25A. DATE REC'D BY HEALTH DEPT.

MAR 9, 1971

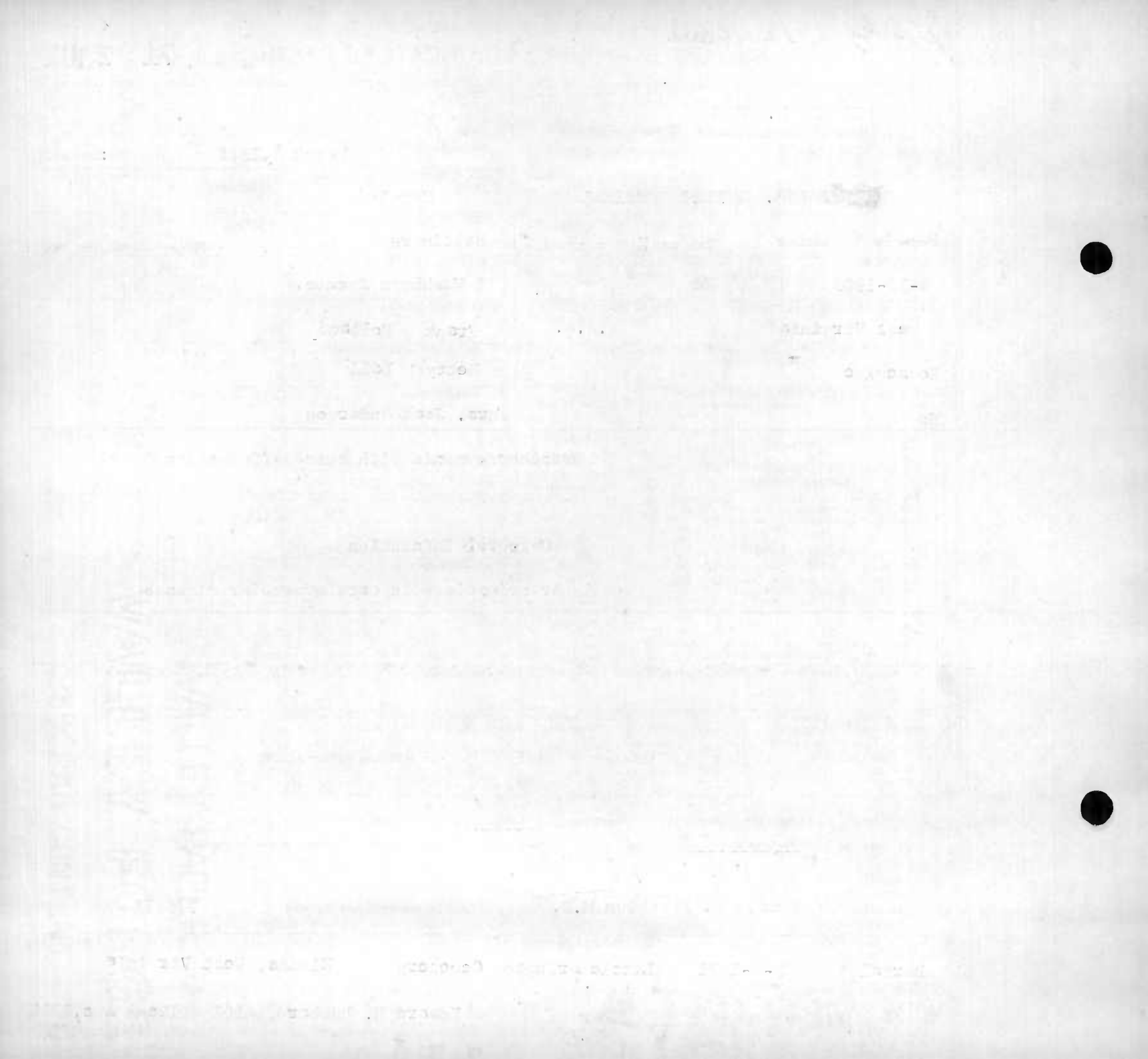
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229



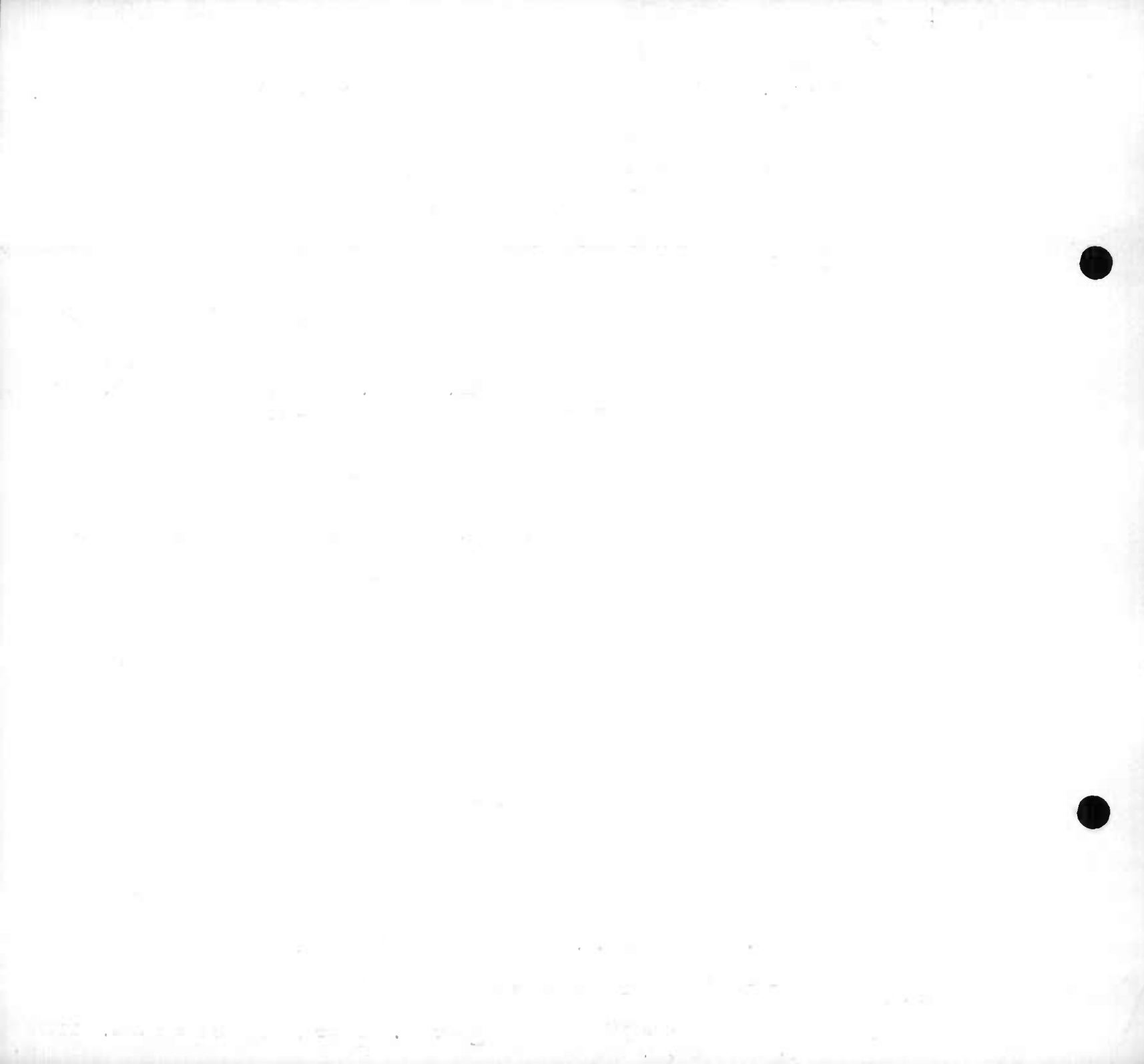
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2302</u> |
|--|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| WHITE, LILLIE JANE | | MARCH 05, 1971 8:15 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229 | | A. STATE MARYLAND | | |
| | | B. COUNTY | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 05-31-88 | | 9. AGE (In years last birthday) 82 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY HOMEMAKER | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Oram | | |
| 14. MOTHER'S MAIDEN NAME ELIZABETH (FOSTER) | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO | | |
| 16. SOCIAL SECURITY NO. DEC 'D | | 17. INFORMANT BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 28 19 71 to MARCH 05 19 71 that (I) (we) last saw the deceased alive on MARCH 05 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE H. GUZMAN M.D. | | | | 23B. DATE SIGNED 3/5/71 |
| 23C. PHYSICIAN'S NAME (Type) DR. H. GUZMAN | | | | 23D. ADDRESS BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-9-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | |
| 25B. NAME OF REGISTRAR Howard H. Hubbard | | 25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229 | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

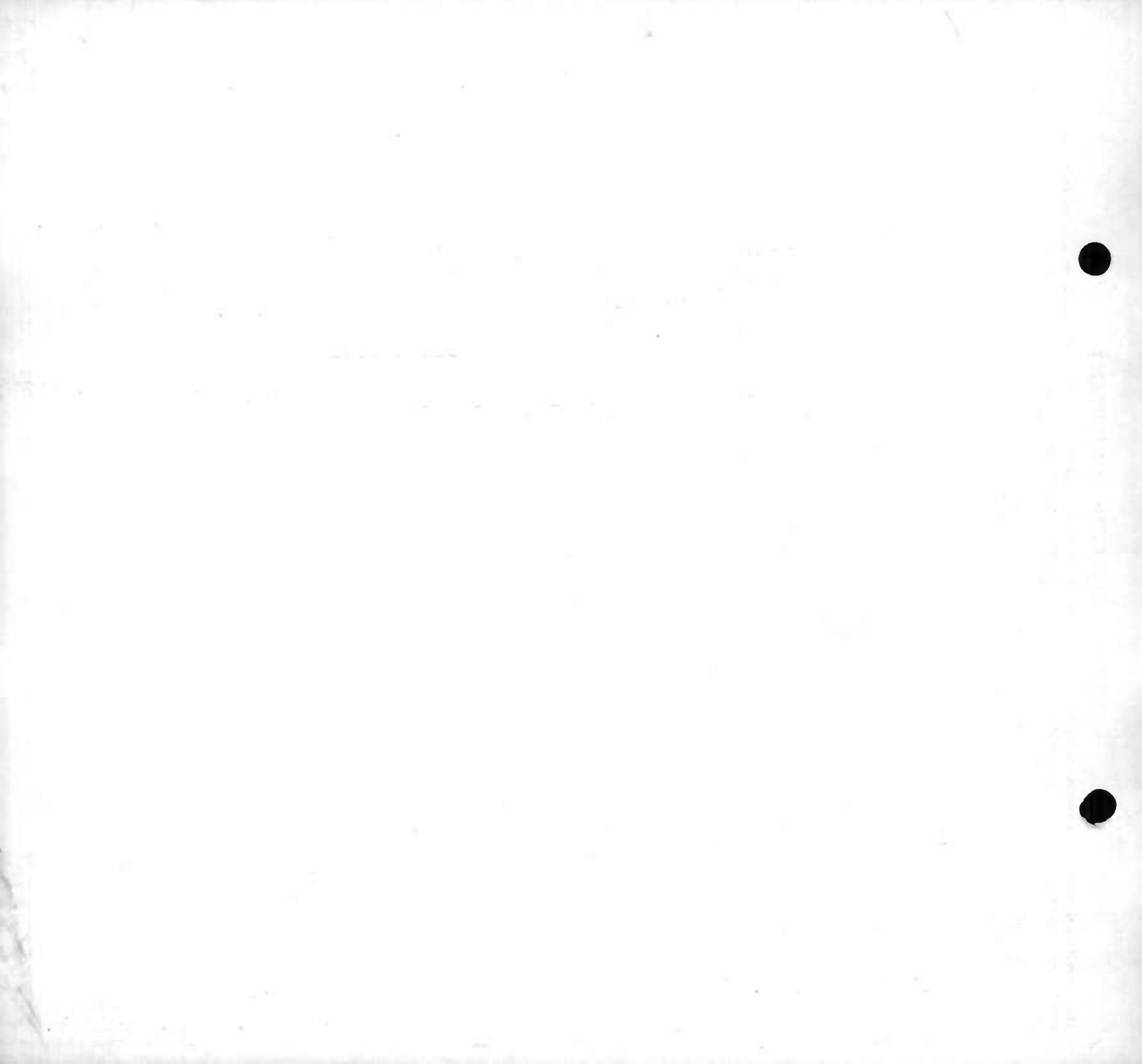
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2303 | | REG. NO. | |
|---|-----------------------------|---|--|---|--|--|--|
| S-530 | | | | 71 2303 | | | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Charles W. Snead | | | | 2. DATE AND HOUR OF DEATH March 5, 1971 10:40 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 19 The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1510 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4011 Belvieu Avenue | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 2, 1886 | | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Middlesex County, Virginia | | |
| 12. CITIZEN OF WHAT COUNTRY? United States | | | 13. FATHER'S NAME John Snead | | | | |
| 14. MOTHER'S MAIDEN NAME Mary ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | | | | |
| 16. SOCIAL SECURITY NO. 219-05-8573A | | | 17. INFORMANT ADDRESS Mrs. Anna V. Snead, 815 Mildred Ave. 21222 Seton Institute - 6400 Wabash Avenue | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (A) IMMEDIATE CAUSE Pneumonia - Lobar (Aspiration) 4 days DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic cardio-vascular disease 5 years DUE TO, OR AS A CONSEQUENCE OF: (C) Psychosis with cerebral arteriosclerosis 2 years | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 24 19 71 to March 5 19 71 that (I) (we) last saw the deceased alive on March 5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Walter O. Jahrreiss, M.D. | | | | 23B. DATE SIGNED March 5, 1971 | | 23C. PHYSICIAN'S NAME (Type) Walter O. Jahrreiss, M.D. | |
| 23D. ADDRESS 6400 Wabash Avenue, Baltimore, Maryland | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 3-9-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Harmony Grove Cemetery | | 24D. LOCATION (City, town, or county) (State) Topping, Virginia | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert A. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2304 | |
|---|--|--|---|--|---|
| BIRTH NO. W-623 | | 71 2304 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED <small>(Type or Print)</small> wright, Leroy C (LEROY C. WRIGHT) | | | 2. DATE AND HOUR OF DEATH 3/15/71 Mar. 5/1971 9 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 14 Union Memorial Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Md MD. C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3211 St Paul St 3211 St. Paul St. | | |
| 5. SEX Male Male | 6. RACE w White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Feb. 8 1927 | 9. AGE (In years last birthday) 46 46 | 10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) un employed | | | 10B. KIND OF BUSINESS OR INDUSTRY Painter-Commercial | | |
| 11. BIRTHPLACE (State or foreign country) Maryland Balto. Md. | | | 12. CITIZEN OF WHAT COUNTRY? USA American | | |
| 13. FATHER'S NAME Mr John Wright | | | 14. MOTHER'S MAIDEN NAME last name Irene Lutman | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII | | | 16. SOCIAL SECURITY NO. 219-10-0449 | | |
| 17. INFORMANT Friend: 3211 St. Paul St. 21218 Miss Christine Purnell | | | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</small> (A) IMMEDIATE CAUSE <u>Liver cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>liver cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| 19. DATE OF OPERATION 3/15/71 | | | 19A. CONDITION FOR WHICH OPERATION WAS PERFORMED II | | |
| 20. AUTOPSY (Yes or No) No | | | 20A. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/28/71 to 3/5/71 that (I) (we) last saw the deceased alive on 3/5/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 23A. SIGNATURE 255 Am. cheikh | | |
| 23B. DATE SIGNED 3/15/71 | | | 23C. PHYSICIAN'S NAME (Type) 255 Am. cheikh | | |
| 23D. ADDRESS Union Memorial Hosp. | | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | |
| 24B. DATE Feb. 8/71 | | | 24C. NAME of CEMETERY or CREMATORY PARKWOOD CEMETERY | | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | |
| 25B. NAME OF REGISTRAR STEWART & MOWEN CO. | | | 25C. FUNERAL DIRECTOR ADDRESS 108 W. North Av. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2305</u> | |
|---|----------------------|--|---|--|--|
| 10-520 BIRTH NO. | | 71 2305 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>JEE WONG (WONG YOKE JEE)</u> | | | 2. DATE AND HOUR OF DEATH <u>3/2/71</u> <u>9:15pm</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>HOUSE IN THE PINES BELVEDERE</u> <u>2525 WEST BELVEDERE AVENUE</u> <u>BALTIMORE MARYLAND 21215</u> | | | A. STATE <u>MARYLAND</u> COUNTY <u>2719</u> | | |
| | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>5514 MINA AKA AVENUE</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>IV</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/20/11</u> | 9. AGE (In years last birthday) <u>59</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN RESTAURANT</u> | | 11. BIRTHPLACE (State or foreign country) <u>AMERICA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | | 13. FATHER'S NAME <u>WONG SUE JEE</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>WHOS JEE</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) <u>UNKNOWN</u> | | |
| 16. SOCIAL SECURITY NO. <u>I36-I2-6390</u> | | | 17. INFORMANT ADDRESS | | |
| 18. <u>16211</u> CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Branchogenic Carcinoma</u> | | | <u>6 month</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last | | | <u>Generalized metastases</u> <u>3 months</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>Feb-18</u> 19 <u>71</u> to <u>March 2</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>March 2</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Alan B. Cohen</u> | | | 23B. DATE SIGNED <u>March 4, 1971</u> | | 23C. PHYSICIAN'S NAME (Type) <u>ALAN B. COHEN</u> |
| 23D. ADDRESS <u>MARYLANDER APT.</u> | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | |
| 24B. DATE <u>2/8/71</u> | | | 24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cem.</u> | | |
| 24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Balto. Co., Md.</u> | | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1971</u> | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Satterly</u> | | | 25C. FUNERAL DIRECTOR ADDRESS <u>STEWART & MOWEN CO. 108 W. North Av. City</u> | | |

MINNOKA AVE.

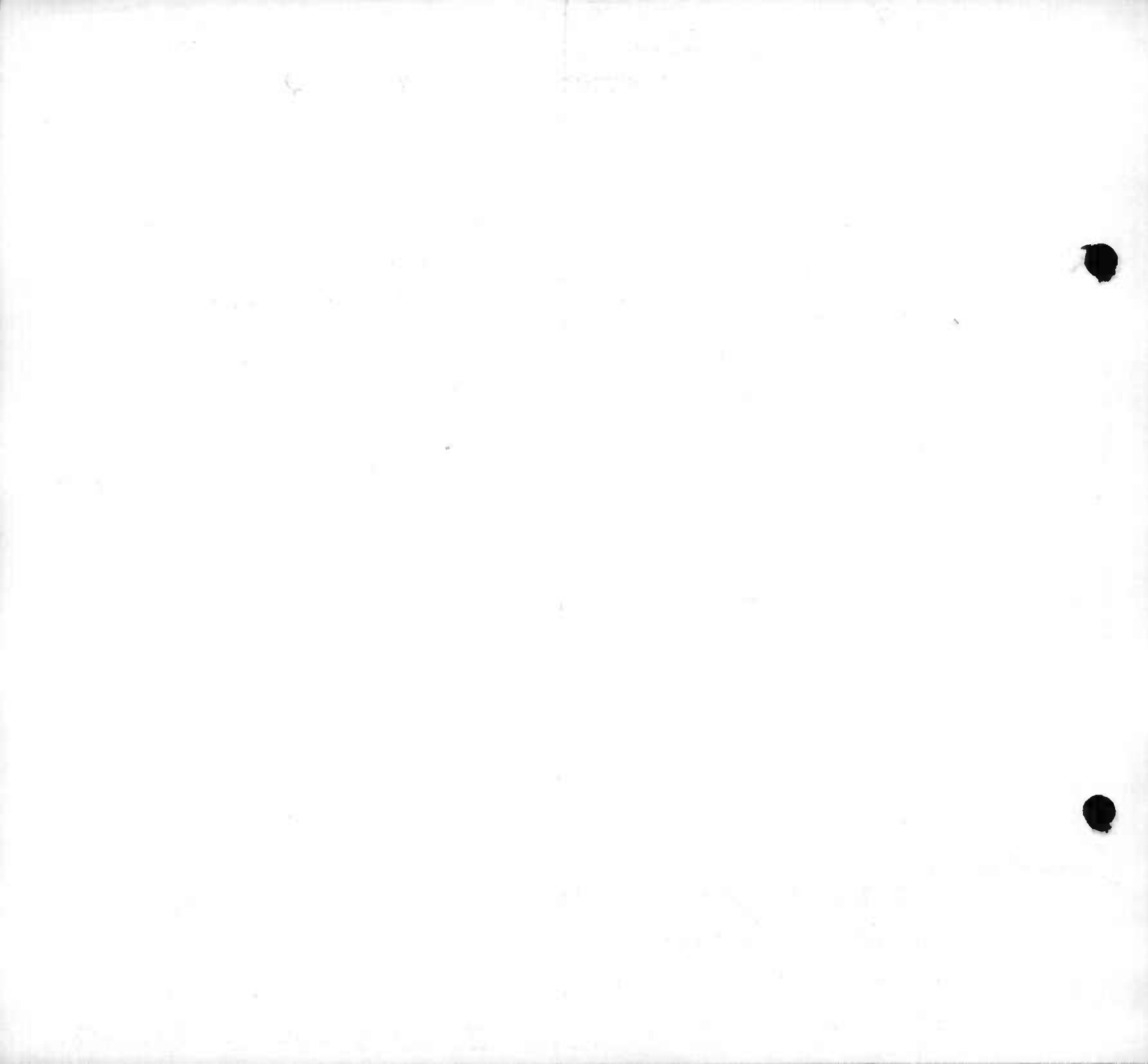
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 71 2306 | |
|--|---|---|--|--|---|
| BIRTH NO. C-654 | | 71 2306 CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Cornell Ervin (ERVIN ELVIN CORNELL) | | 2. DATE AND HOUR OF DEATH 3/7/71 3/7/71 6:55 M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1203 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 2738 Guilford Avenue | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/11/84 | 9. AGE (In years last birthday) 87 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY CARPENTER | | 11. BIRTHPLACE (State or foreign country) N. York (New York) | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Elvin W. Cornell (D) | | 14. MOTHER'S MAIDEN NAME Imogene Tice | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 116-03-3575 | | 17. INFORMATION ADDRESS HOSPITAL Chart-2724 N. Charles St. | |
| 18. 199.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMATOSIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/7 19 71 to 3/7 19 71 that (I) (we) last saw the deceased alive on 3/7 19 71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. H. KELEMEN | | 23B. DATE SIGNED 3/7/71 | | 23C. PHYSICIAN'S NAME (Type) M. H. KELEMEN | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/10/71 | | 24C. NAME OF CEMETERY OR CREMATORY Hillside Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Peekskill, New York | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Gable, M.D. | |
| 25C. FUNERAL DIRECTOR Stewart Mowen | | 25D. ADDRESS 108 W North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2307 | |
|--|--|---|--|---|--|
| G-635 66-097971 2307 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| GROTTENDICK, MICHAEL JOSEPH, | | | 03 06 71 5:55 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL | | | A. STATE MARYLAND B. COUNTY HOWARD | | |
| 5. SEX MALE | | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 05 5 66 | | | 9. AGE (In years last birthday) 4 | | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD | | | 10B. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME JOSEPH GROTTENDICK | | |
| 14. MOTHER'S MAIDEN NAME MARY (HOPWOOD) GROTTENDICK | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. --- | | | 17. INFORMANT CATON AVES BALTO MD 21229 ST AGNES HOSPITAL RECORDS WILKENS & | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH mid brain hemorrhage encephalitis viral (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio Respiratory arrest (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that XXX (this hospital) attended the deceased from 03 04 19 71 to 03 06 19 71 that XX (we) last saw the deceased alive on 03 06 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. XXX (We) (did) XXX view the body after death. | | | | | |
| 23A. SIGNATURE S.Y. HUH, M.D. Sung Y. HUH M.D. | | | 23B. DATE SIGNED 3-6-1971 | | 23C. PHYSICIAN'S NAME (Type) S.Y. HUH, M.D. |
| 23D. ADDRESS St Agnes Hospital | | | 24. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 3/9/71 | | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | |
| 24D. LOCATION Baltimore, Maryland | | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | |
| 25B. NAME OF REGISTRAR R. E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR Sterling Funeral Estate 736 Edmondson Ave. Catonsville, Md 21043 | | |

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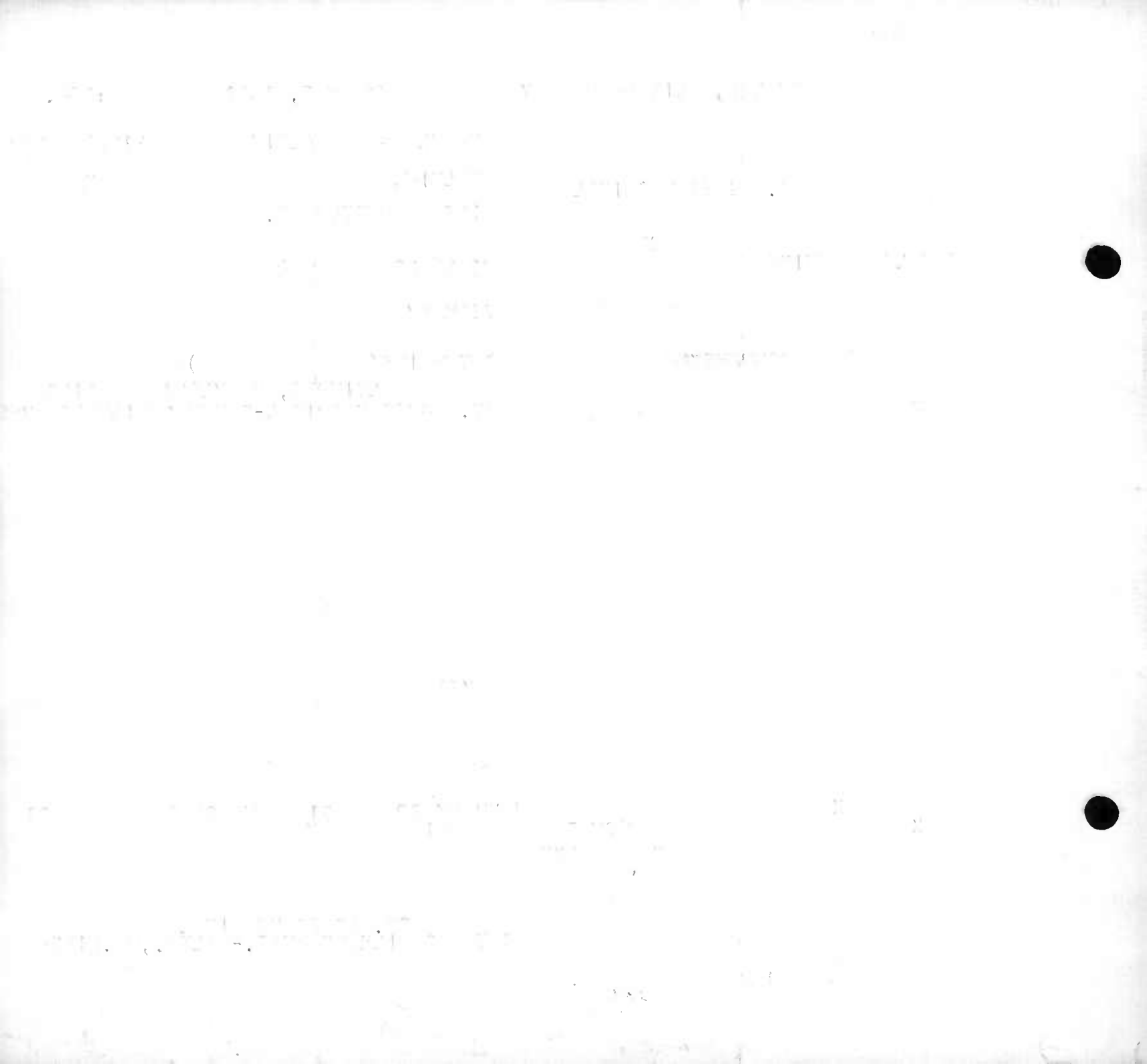
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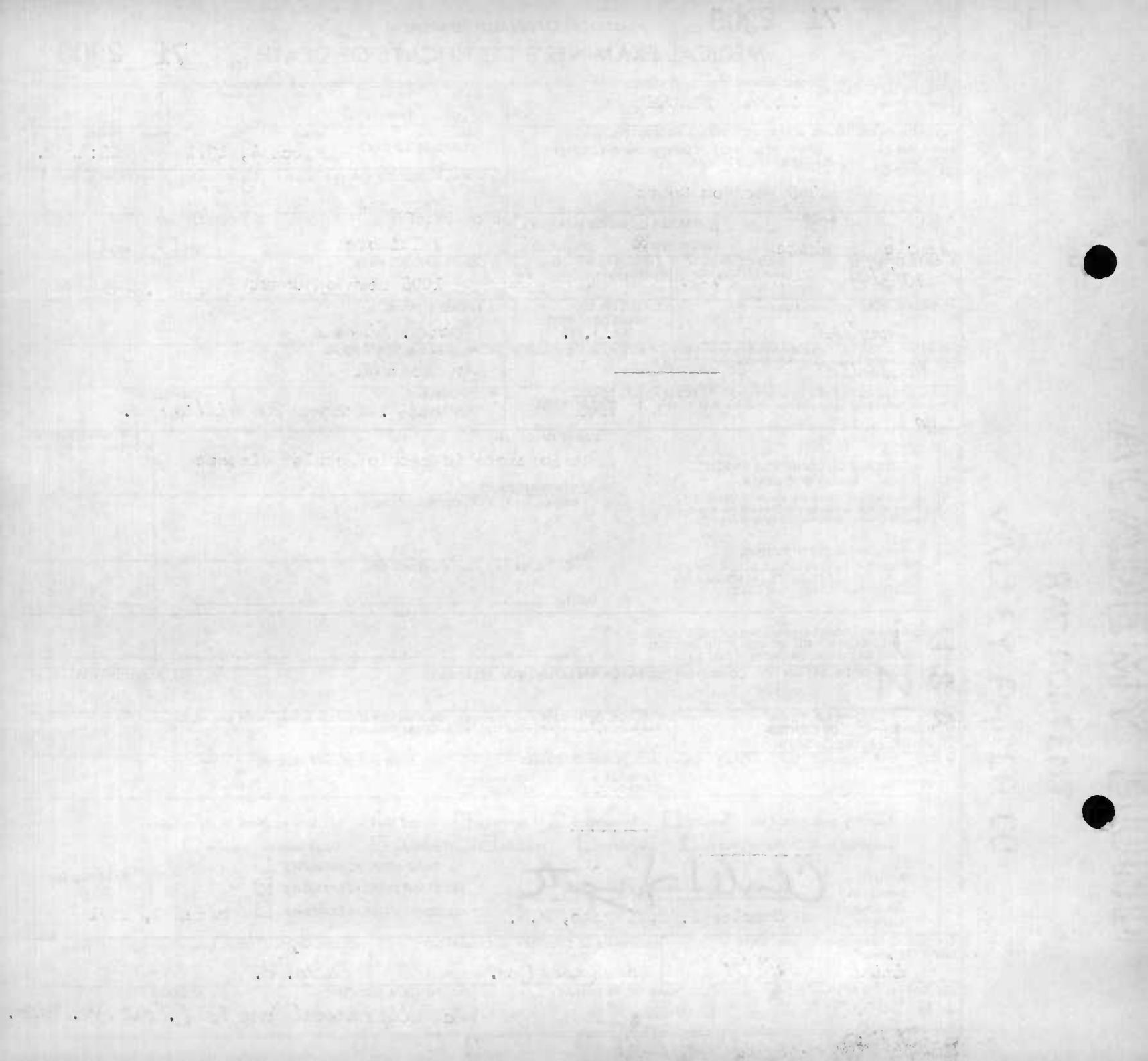
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|---|---|---|--|--|
| HBU 1 | | 71 2308 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 71 2308 | |
| S-542 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) SMOLEK, ELIZABETH MARY | | | | 2. DATE AND HOUR OF DEATH MARCH 7, 1971 8:20A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 21227 5300 1258 BREWSTER ST. | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 03 26 22 | 9. AGE (In years last birthday) 48 | If Under 1 Tr. Months: Days: Hours: Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector | | | 10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Albert Kramer SCHUSMEYER | | | | 14. MOTHER'S MAIDEN NAME CATHERINE (Schusmeyer) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 219-16-5490 | | 17. INFORMANT BALTIMORE, MARYLAND ADDRESS 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES | | | |
| 18. 154.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma recto sigmoid & multiple metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 154.01 | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs. | | | |
| 19A. DATE OF OPERATION 2/7/1969 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED colostomy | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ST. AGNES HOSPITAL | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? ST. AGNES HOSPITAL | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 30 19 71 to MARCH 7 19 71 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 7 19 71 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Jose Opler, M.D. | | | | 23B. DATE SIGNED 3/7/71 | | 23C. PHYSICIAN'S NAME (Type) Jose Opler, M.D. | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE 3/10/71 | | 24C. NAME OF CEMETERY OR CREMATORY meadowridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Dorsey Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, R.D. | | 25C. FUNERAL DIRECTOR Amberg & Inc 1329 Sulphur Sp. Rd. | | | |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. 71 2309 | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| BIRTH NO. 8-326 | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) FRED A STECKER | | | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | | | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1005 Herndon Court | | | | | | 3. DATE PRONOUNCED DEAD March 4, 1971 12:15 P. M. | | | | | |
| 6. SEX Female | | | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2505 | | | | | |
| 7. RACE White | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | | | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 9. DATE OF BIRTH 10/2/99 | | 10. AGE (in years) 70 71 | | E. STREET AND NUMBER 1005 Herndon Court | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME John J. Birrane | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 14B. KIND OF BUSINESS OR INDUSTRY | | | | 15. MOTHER'S MAIDEN NAME Eva Hartman | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 17. SOCIAL SECURITY NO. none | | | | 18. INFORMANT Robert E. Steckerv 206 Hilltop Rd. ADDRESS | | | |
| 19. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) No | | | | | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 4, 1971 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/71 | | 24C. NAME OF CEMETERY or CREMATORY Holy Cross Cem. | | | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR Mc Cully Funeral Home 130 E. Font Ave. Balto. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 71 2310 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | | 71 2310 | |
|--|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) MR. HENZE, GEORGE E. P. | | | | 2. DATE AND HOUR OF DEATH 3/6/1971 5:45 A.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4/ UNION MEMORIAL HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1307 | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX MALE | | | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 09-08-'84 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Golf Pro | | | | 10B. KIND OF BUSINESS OR INDUSTRY Clifton Pk. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? AMERICA | |
| 13. FATHER'S NAME MR. WILLIAM HENRY | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN Burns | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - | | | |
| 16. SOCIAL SECURITY NO. 213-01-6276 | | | | 17. INFORMANT ADDRESS U.M. Hosp. Admission History | | | | | |
| 18. 441.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHOPNEUMONIA, due to Post - CARDIAC ARREST ALSO ACUTE MYOCARDIAL INFARCTION (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ABDOMINAL ANEURYSM series pulm. edema effusion | | | | | |
| 19A. DATE OF OPERATION 3/5/71 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Difficulty Breathing | | 20A. AUTOPSY (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) - | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 02-24-1971 to 03-06-1971 that (I) (we) last saw the deceased alive on 03-06-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Rau | | | | 23B. DATE/SIGNED 3/6/71 | | 23C. PHYSICIAN'S NAME (Type) DR. R. RAU | | | |
| 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | | 23E. ADDRESS UNION MEMORIAL HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/16/71 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Pk Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 | | 25B. NAME OF REGISTRAR D. B. E. J. J. J. | | 25C. FUNERAL DIRECTOR Donovan Funeral Home | | 25D. ADDRESS 3818 Roland ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

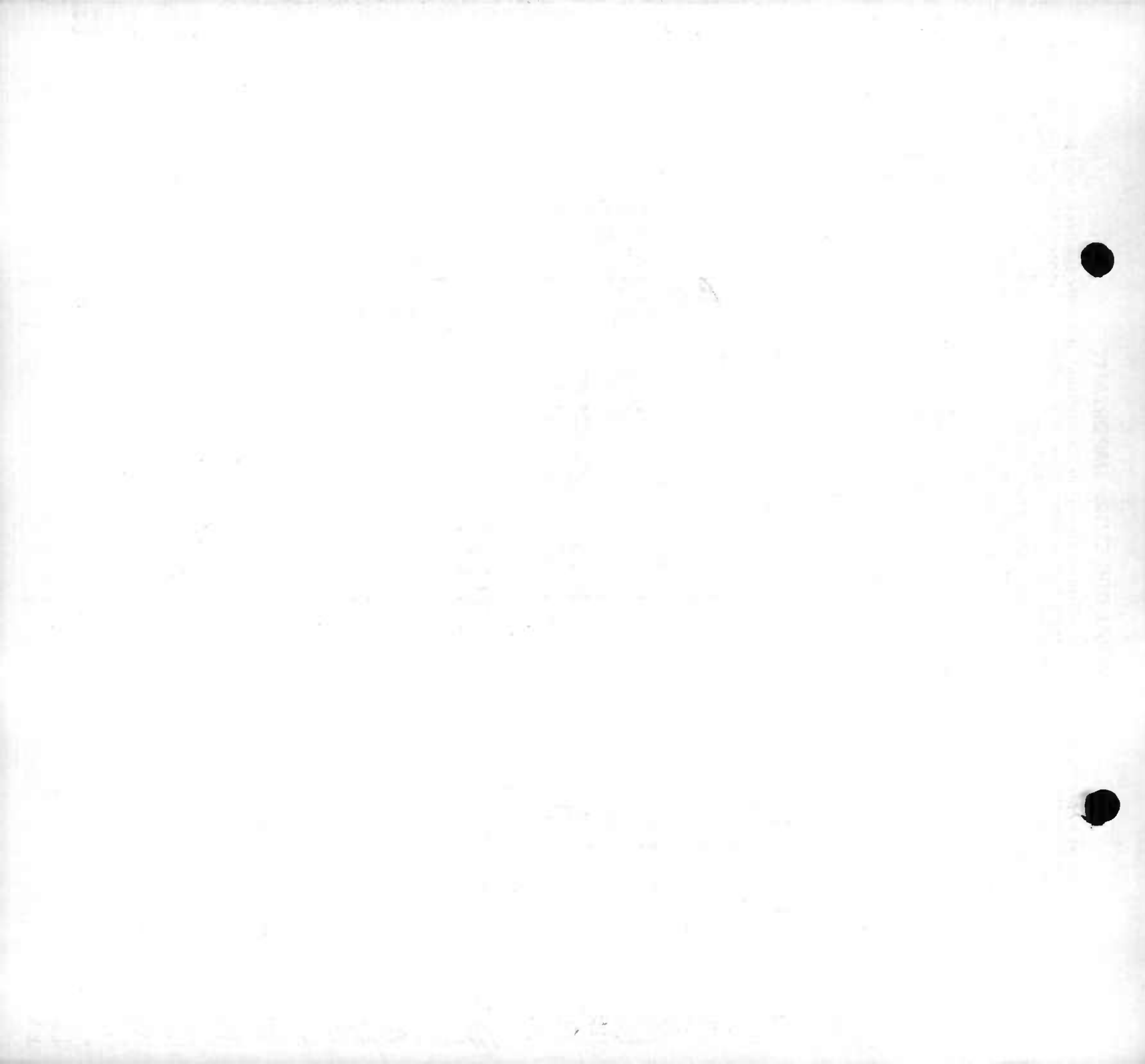
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2311 |
|--|---|---|---|--|
| 1. NAME OF DECEASED (Type or Print) REED, ELIZABETH SOPHIA | | 2. DATE AND HOUR OF DEATH March 4, 1971 10:30 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO. C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? 5300 Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 57 Dundalk Ave. | | |
| 5. SEX Female | 6. RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 05-07-97 | 9. AGE (In years last birthday) 73 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pennsylvania |
| 12. CITIZEN OF WHAT COUNTRY? American | | 13. FATHER'S NAME Unknown | | |
| 14. MOTHER'S MAIDEN NAME HESS | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 215-34-9254 | | 17. INFORMANT Mr. Charles M. Reed, Sr. Same | | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) H/o pernicious anemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks years | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 26 19 71 to March 4 19 71 that (I) (we) last saw the deceased alive on March 4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE John Ohe | | 23B. DATE SIGNED March 4, 1971 | | 23C. PHYSICIAN'S NAME (Type) John OHE |
| 23D. ADDRESS Union Memorial Hospital | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | |
| 24B. DATE 3/6/71 | | 24C. NAME OF CEMETERY OR CREMATORY OAK LAWN | | 24D. LOCATION (City, town, or county) (State) BALTO. CO. MD. |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR John E. Kelly, Jr. | | 25C. FUNERAL DIRECTOR W. D. Kelly, Dundalk, Md. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|-------------------------|---|---|---|---|--|---|--|--|--|
| B-550 71 2313 | | | | | CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | | | | REG. NO. 71 2313 | | | | | |
| 1. NAME OF DECEASED (Type or Print) BAUMANN, Louis | | | | | 2. DATE AND HOUR OF DEATH 3-7-71 2:05 A.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE Maryland | | B. COUNTY 21230 2302 | | | |
| | | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | E. STREET AND NUMBER 29 E. Fort Ave. | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-4-86 | 9. AGE (In years lost birthday) 84 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY Patapco Scrap Corp. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Paul As Baumann | | | | | 14. MOTHER'S MAIDEN NAME Unk | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) Unknown | | | | 16. SOCIAL SECURITY NO. 213-10-7200 | | 17. INFORMANT Alice M. Sirbaugh-Daughter | | | ADDRESS (Same) | |
| 18. 4-10-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: coronary insufficiency | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic cardiovascular disease | | | | | 10 days |
| | | | | | (C) part - bowel obstruction | | | | | 3 wks |
| II | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | |
| 19A. DATE OF OPERATION 3-5-71 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal surgery | | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) Month (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-5-71 to 3-6-71 that (I) (we) last saw the deceased alive on 3-5-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Narong Ruangruchira | | | | | | | | 23B. DATE SIGNED 3-6-71 | | |
| 23C. PHYSICIAN'S NAME (Type) NARONG RUANGRUCHIRA | | | 23D. ADDRESS S BGH, 3001 S. Hanover St. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE 3/10/71 | | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem | | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | | 25B. NAME OF REGISTRAR John E. [Signature] | | | 25C. FUNERAL DIRECTOR McBride H. 130 E Fort ave | | | ADDRESS 1130 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

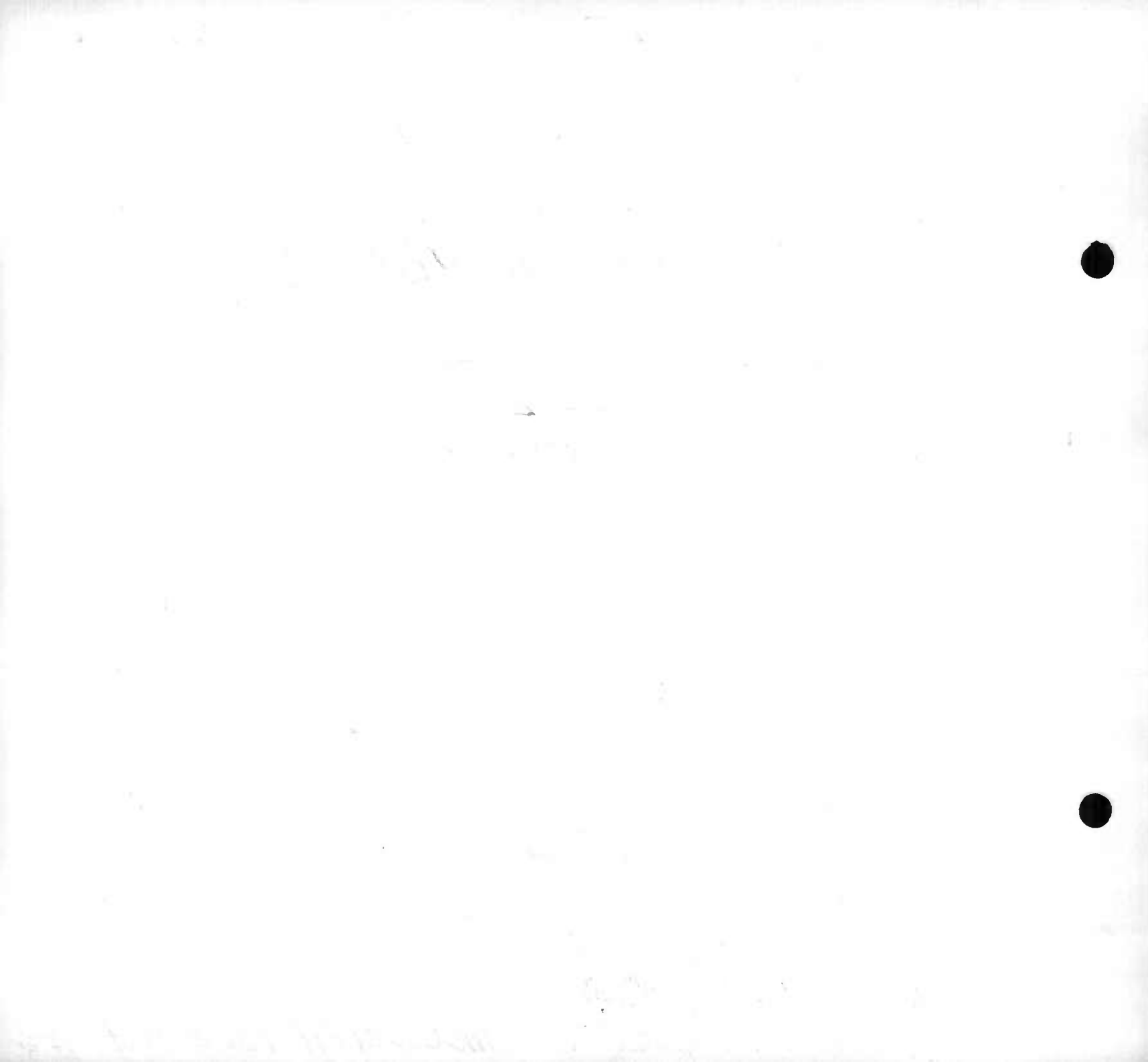
| | | | | | | | |
|---|---------------------|---|--|---|--|--|------------------------------|
| BIRTH NO. W-410 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2312 | | 71 2312 | |
| 1. NAME OF DECEASED (Type or Print) MARIEM. WOLF | | | | 2. DATE AND HOUR OF DEATH MAR 5, 1971 6:15 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME S' HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2611 | | | |
| | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 521 S. East Ave. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/3/28 96 | 9. AGE (in years last birthday) 74 283 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME JNGAUS RITTER | | | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Niece | |
| | | | | ADDRESS 1764 Brookview Rd | | | |
| 18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCAD | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: severe congestive heart failure | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Plural effusion | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 2-18-1971 to 3-5-1971 that (H) (we) last saw the deceased alive on 3-5-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ardu Samad MD | | | | | | 23B. DATE SIGNED 3-5-1971 | |
| 23C. PHYSICIAN'S NAME (Type) ARDUS SAMAD MD | | | | | | 23D. ADDRESS Church Home S' Hospital Baltimore MD (31) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Harbor MD | | 25C. FUNERAL DIRECTOR John A. Moran, Inc. | | ADDRESS 3000 E. Baltimore St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2314 | |
|--|--|--|--|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. R-255 | | 71 2314 | | DATE AND HOUR OF DEATH 3/7/71 6⁰⁵ 4^{PM} | |
| 1. NAME OF DECEASED <small>(Type or Print)</small> RICHMOND, LOUISE | | | | 2. DATE AND HOUR OF DEATH 3/7/71 6⁰⁵ 4^{PM} | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MONTEBELLO STATE HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE CITY C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTO YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3112 D WALLFORD DRIVE 5300 | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 2/21/15 | 9. AGE (In years last birthday) 55 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Louis Kohlhoff | | |
| 14. MOTHER'S MAIDEN NAME Louise Smith | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 212-26-6195 | | | 17. INFORMANT ADDRESS Mrs Alice M Sirbaugh Same | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</small> CAACINOMA of LUNG | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21B. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small> | | | |
| 21C. TIME OF INJURY (APPROX.) <small>(Month) (Day) (Year) (Hour)</small> | | 21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21E. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from JAN 29 19 71 to MAR 7 19 71 that (we) last saw the deceased alive on 3/7 19 71 and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph Kenneth Marshall, Jr. M.D. | | | | 23B. DATE SIGNED 3/7/71 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH KENNETH MARSHALL JR M.D. | | | | 23D. ADDRESS MONTEBELLO STATE HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/71 | | 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem | |
| 24D. LOCATION <small>(City, town, or county)</small> <small>(State)</small> Ritchie Hwy AA Co Md | | 25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR MAR 9 1971 Robert E. Taylor, R.D. | | | |
| 25C. FUNERAL DIRECTOR ADDRESS McBully F.H. 130 E Fort ave | | | | | |



1
T-52 71 2315 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 2315

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) ANDREW W. THOMPSON | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 3-5-71 11:15 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTO. GENERAL HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 5, 1971 11:15 P.M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2301 | |
| 9. DATE OF BIRTH 4/1/14 | | 10. AGE (in years last birthday) 56 | |
| 11. BIRTHPLACE (State or foreign country) Md | | 12. CITIZEN OF USA | |
| 13. FATHER'S NAME John W Thompson | | 14. MOTHER'S MAIDEN NAME Mary B Johnson | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Md Drydock | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Robert W Thompson 4121 Shannon Dr 21213 | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (Approx.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/11/71 | |
| 24C. NAME OF CEMETERY or CREMATORY Western Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Mr. Cully F.H. 130 F North Ave. | | ADDRESS 130 F North Ave. | |

2025-12-15

CHS IV 107

Mr. G. H. 1907

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2316 | |
|---|--|--|--|---|---|
| BIRTH NO. M-213 | | 71 2316 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ETHEL J. McFADDEN | | | 2. DATE AND HOUR OF DEATH 3/7/71 11 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1307 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 720 W 36th St | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/31/06 | 9. AGE (In years last birthday) 64 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROOF READER | | | 10B. KIND OF BUSINESS OR INDUSTRY PRINTING | | |
| 11. BIRTHPLACE (State or foreign country) Md | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Charles E Mixer | | | 14. MOTHER'S MAIDEN NAME Olive M Downin | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 214034823 | | |
| 17. INFORMANT Vernon L Mixer | | | ADDRESS Kissimmee Florida | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> (A) IMMEDIATE CAUSE Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Uremia DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/2 19 71 to 3/7 19 71 that (I) (we) last saw the deceased alive on 3/7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 3/7/71 | |
| 23C. PHYSICIAN'S NAME (Type) JACQUES KHOURY | | | | 23D. ADDRESS Union Memorial Hospital | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 11 MAR 71 | | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem | |
| 24D. LOCATION (City, town, or county) (State) Pikerville Bz to Co Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR Burger Funeral Home Bz to Md | | | |

10/20/77 B Resp. Arrest

B. Uremia

C - Hypertension, CHF

Additional Information from query to
Union Memorial Hosp - Filed in Bur. of Prisons
ge

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2317</u> | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>WILLIAM E. MELIA</u> | | 2. DATE AND HOUR OF DEATH <u>March 2, 1971 9⁴⁵ P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Montebello STATE HOSP.</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1206</u> | | | |
| 5. SEX <u>M</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Oxygen Mfg.</u> | | 8. DATE OF BIRTH <u>11-7-97</u> | |
| 13. FATHER'S NAME <u>ROBERT E. MELIA</u> | | 14. MOTHER'S MAIDEN NAME <u>Georgia Grooms</u> | | 9. AGE (in years last birthday) <u>73</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216 057202</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 17. INFORMANT <u>HOSPITAL RECORD</u> | | ADDRESS | | | |
| 18. <u>43617 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular accident</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>7 years</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>July 7, 1963</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1963</u> to <u>Mar 2, 1971</u> that (I) (we) last saw the deceased alive on <u>Mar 2, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Frederick Pearson MD.</u> | | | | 23B. DATE SIGNED <u>3-2-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>FREDERICK PEARSON, MD.</u> | | | | 23D. ADDRESS <u>Univ of Md. Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>6 March 71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem</u> | |
| 24D. LOCATION <u>Baltimore Md</u> | | 25A. DATE RECEIVED BY HEALTH DEPT. <u>MAR 9 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Base</u> | | 25C. FUNERAL DIRECTOR <u>Burger Funeral Home Balto Md</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 71 2318 | |
|--|--|--|--|---|--|---|--|
| BIRTH NO. D-400 71 2318 | | | | 1. NAME OF DECEASED (Type or Print) DILL, ROBERT JOSEPH | | 2. DATE AND HOUR OF DEATH 03 04 71 10:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE DELAWARE B. COUNTY V-07 | | C. CITY OR TOWN DELMAR D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX MALE | | | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 09 24 32 | | | | 9. AGE (in years last birthday) 38 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHICKEN VACCINATOR | | | | 10B. KIND OF BUSINESS OR INDUSTRY SERVICE HUDSON VACCINATING | | 11. BIRTHPLACE (State or foreign country) DELAWARE | |
| 12. CITIZEN OF WHAT COUNTRY? US | | | | 13. FATHER'S NAME LAWRENCE DILL | | | |
| 14. MOTHER'S MAIDEN NAME ALMA (WYATT) | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 220 28 0591 | | | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 430.91 + 011.9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pulmonary Tuberculosis | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sub arachnoid tumor stage (B) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Tuberculosis? (C) _____ | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19A. DATE OF OPERATION 2-22-71 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED lung biopsy | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 03 04 71 19 71 to 03 04 19 71 that (I) (we) last saw the deceased alive on 03 04 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Hermenegildo Isidro | | | | 23B. DATE SIGNED March 5, 1971 | | 23C. PHYSICIAN'S NAME (Type) HERMENEGILDO ISIDRO, M.D. | |
| 23D. ADDRESS BALTO MD 21229 | | | | 23E. NAME OF CEMETERY OR CREMATORY ST AGNES HOSPITAL CATON & WILKENS AVES | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 3/7/71 | | 24C. LOCATION (City, town, or county) (State) Delmar Wicomico Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS 2 MAR 11 78.R | |

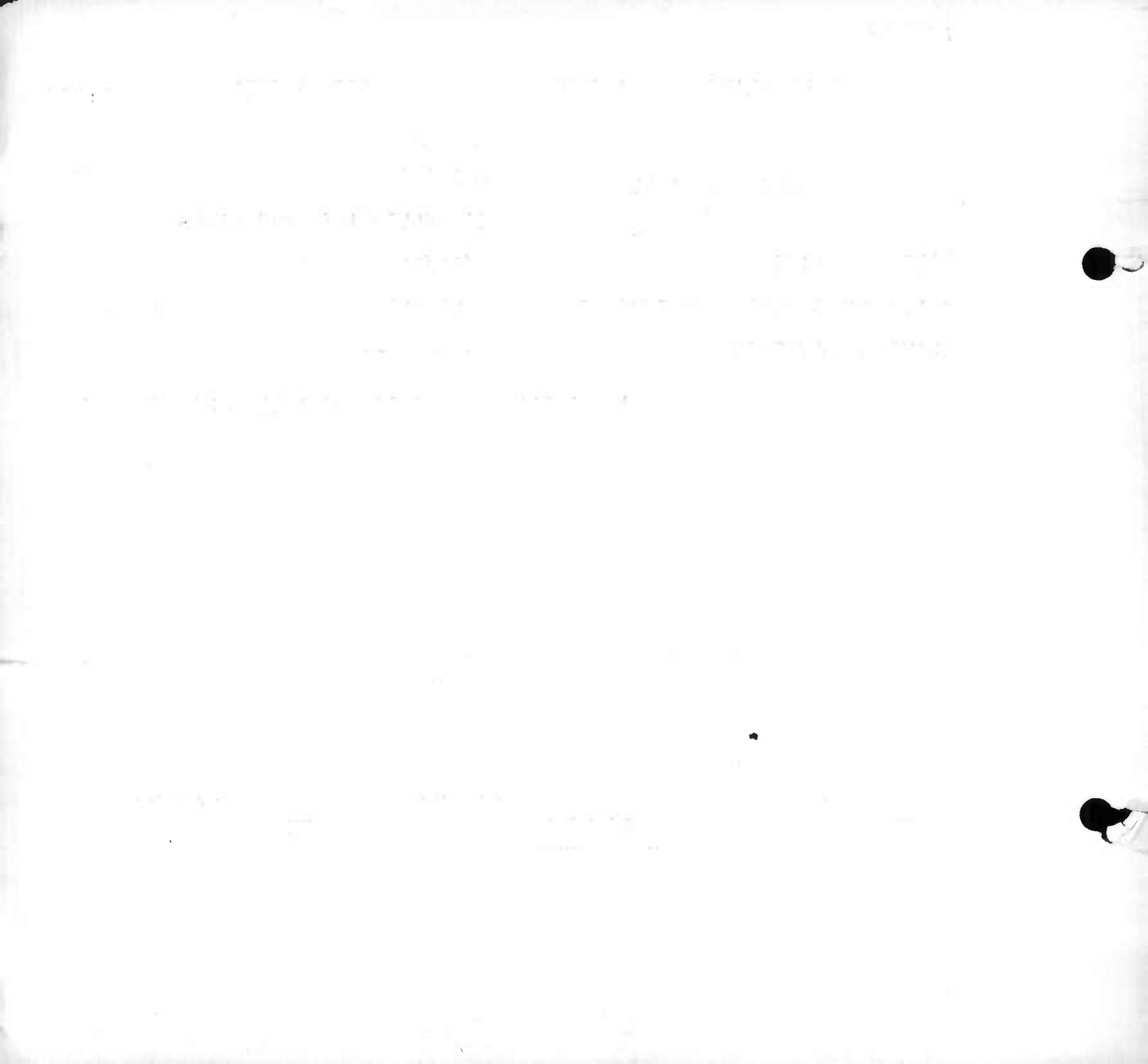
56 R.

March 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 71 2319 | | | | | | | | | | |
| BIRTH NO. P-500 71 2319 | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) PAYNE OLIVER WASHINGTON | | | | | 2. DATE AND HOUR OF DEATH MARCH 7 1971 2:05P M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 610 COLERAINE ROAD 21229 | | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 04/13/11 | | 9. AGE (In years last birthday) 59 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAST GUARD YARD | | | | | 10B. KIND OF BUSINESS OR INDUSTRY US GOVERNMENT | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME OLIVER W PAYNE SR | | | | | 14. MOTHER'S MAIDEN NAME EMMA MEETH | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215 03 7334 | | 17. INFORMANT ADDRESS ST AGNES HOSPITAL BALTO MD 21229 | | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | |
| <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Uremia; bilateral hydronephrosis</i></p> <p>(B) <i>Carcinoma, urinary bladder</i> DUE TO, OR AS A CONSEQUENCE OF: <i>with metastases</i></p> <p>(C) _____</p> | | | | | | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> <p><i>Pulmonary Emphysema</i></p> | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in at about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (this hospital) attended the deceased from 03/03/71 to 03/07/71 | | that (we) last saw the deceased alive on 03/07/71 | | and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. | | | | | | |
| 23A. SIGNATURE <i>Dr. Alonzo</i> | | | | | 23B. DATE SIGNED | | | 23C. PHYSICIAN'S NAME (Type) Adolfo ALONZO | | |
| 23D. ADDRESS <i>St Agnes Hospital</i> | | | | | 23E. ADDRESS <i>Caton & Wilkins Ave 21229</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/10/71 | | 24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD.</i> | | 25C. FUNERAL DIRECTOR <i>John T. Taylor</i> | | 25D. ADDRESS 21228 | | | | |



| 71 2320 BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | |
| BIRTH NO. 70-23500 | | REG. NO. 71 2320 | |
| 1. NAME OF DECEASED (Type or Print) Karen Angela Mack | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2211 Whittier Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 3 2 71 7:05 a M. | |
| 6. SEX female | | 7. RACE colored | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 12-26-70 | | 10. AGE (In years lost birthday) 2 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Junius C. Mack | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | |
| 15. MOTHER'S MAIDEN NAME Sheila M. Adams | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 17. SOCIAL SECURITY NO. none | | 18. INFORMANT Junius Mack 2211 Whittier Ave. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>Werner U. Spitz</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner 3/2/71 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-71 | |
| 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Charles A. Rice | |
| 25C. FUNERAL DIRECTOR Charles A. Rice | | 25D. ADDRESS 661 W. Barre St. | |

THE COURT'S JUDICIAL ACTIVITIES IN 1960-1961

THE COURT'S JUDICIAL ACTIVITIES IN 1960-1961

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|-----------------------------------|--|---|
| <div style="display: flex; justify-content: space-between;"> G-510 71 2331 </div> | | CERTIFICATE OF DEATH | | REG. NO. 71 2331 | |
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) GEORGE GUMBY | | 2. DATE AND HOUR OF DEATH 3/6/71 4:40P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2101 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 707 PORTLAND STREET | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/8/07 | 9. AGE (In years lost birthday) 64 | 10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN | | 10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME GEORGE GUMBY | | 14. MOTHER'S MAIDEN NAME ANNIE ALLEN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | 16. SOCIAL SECURITY NO. UNK. | | 17. INFORMANT ADDRESS PATIENT IDA GUMBY 707 Portland St. | |
| 18. 157.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Pancreas | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Brain Syndrome | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| 19A. DATE OF OPERATION 2/11/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca Pancreas | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/3 19 71 to 3/6 19 71 , that (I) (we) last saw the deceased alive on 3/6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE George J. Berakha | | 23B. DATE SIGNED 3/6/71 | | 23C. PHYSICIAN'S NAME (Type) GEORGE J. BERAKHA MD | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/11/71 | | 24C. NAME OF CEMETERY or CREMATORY Green Acre | |
| 24D. LOCATION (City, town, or county) (State) Salisbury Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | |
| 25C. FUNERAL DIRECTOR Charles A. Rice | | ADDRESS 6614 Barre St | | | |

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| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
|--|--|---|--|--|--|---|--|---|--|
| MARY PORTER | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> March 3, 1971 | | March 3, 1971 | | Maryland General Hospital | | Maryland | |
| F. FULL NAME OF HOSPITAL OR INSTITUTION | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | A. STATE | |
| 48 Maryland General Hospital | | Female | | Negro | | Baltimore | | B. COUNTY | |
| 6. SEX | | 7. RACE | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 9. DATE OF BIRTH | | 10. AGE (In years lost birthday) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| 12/25/00 | | 70 | | South Carolina | | U.S.A. | | Lee Nash | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| | | | | Rosa Brown | | | | 217-09-5118 | |
| 18. INFORMANT | | ADDRESS | | 19. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Amos Paul | | 2000 W. Fayette St. | | Arteriosclerotic cardiovascular disease | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | | | | |
| 0 | | | | No | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (APPROX.) | | 22E. INJURY OCCURRED | |
| | | | | | | | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 24. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| | | | | Burial | | 3/9/71 | | Mt. Auburn | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| MAR 9 1971 | | Robert E. Taylor, M.D. | | Charles A. Rice | | 661 W. Barre St. | | | |

ACADEMY ROAD

THE COMPANY

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

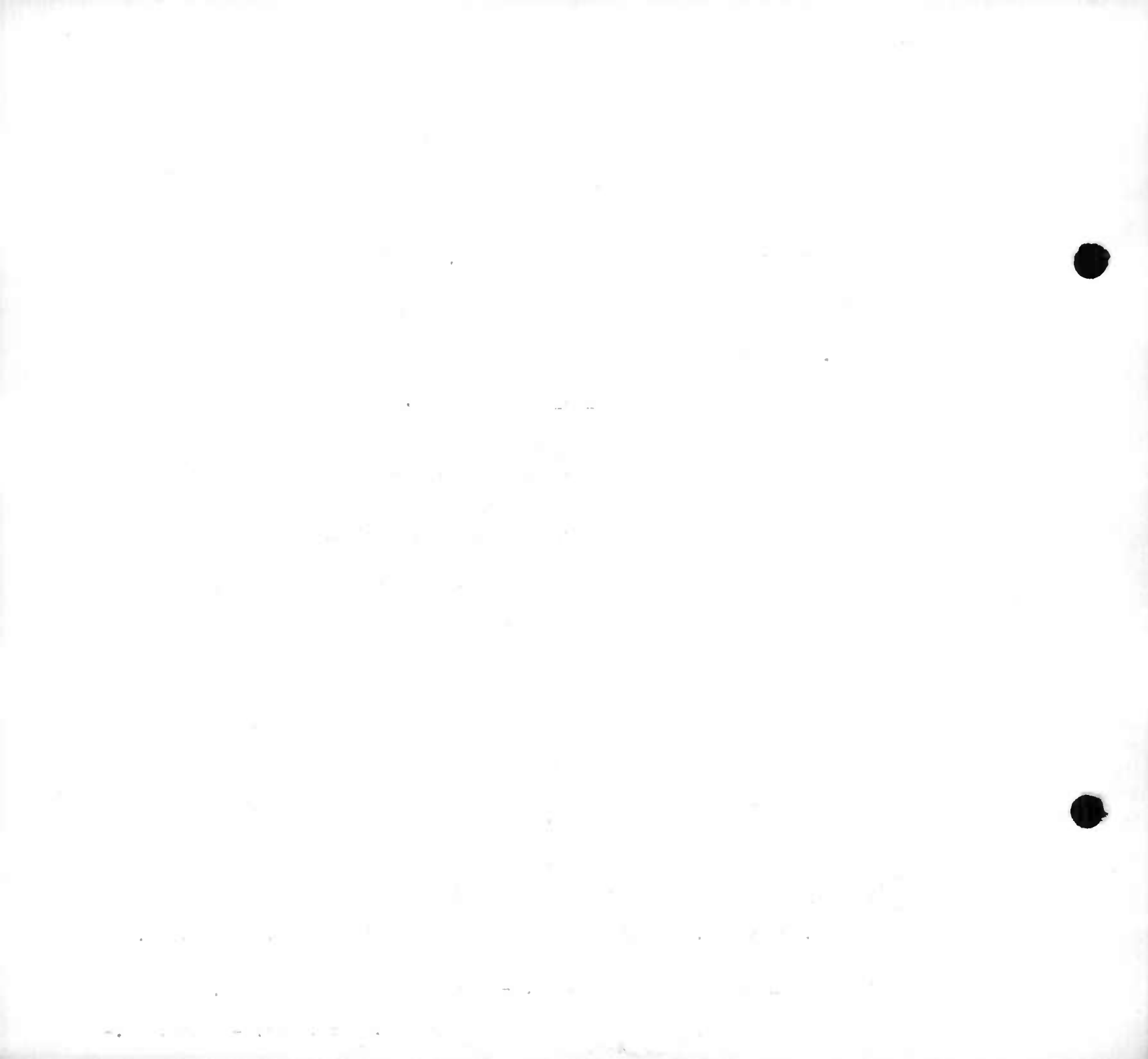
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2323 | |
|--|--|--|---|------------------|---|
| <p>RELEASED by Medical G-450 Examiner 2323</p> <p>CERTIFICATE OF DEATH</p> | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>MATTHEW GLENN</u> | | | 2. DATE AND HOUR OF DEATH <u>3-5-71</u> <u>7:30 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>49 NORTH CHARLES GEN. HOSPITAL</u> <u>28th Charles St. Balto Md.</u> | | | A. STATE <u>MD.</u> & COUNTY <u>USA</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | E. STREET AND NUMBER <u>3974 EDGEHILL AVE. BALTO. MARYL.</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retail Pharmacy</u> | | 8. DATE OF BIRTH <u>8-10-98</u> |
| 13. FATHER'S NAME <u>ADAM GLENN</u> | | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH GALBRAITH</u> | | 9. AGE (In years last birthday) <u>72</u> |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u> | | | 16. SOCIAL SECURITY NO. <u>147 09 6241</u> | | 11. BIRTHPLACE (State or foreign country) <u>SCOTLAND</u> |
| 17. INFORMANT <u>NORTH CHARLES GEN HOSPITAL</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEPTIC SHOCK</u> |
| 19. DATE OF OPERATION <u>3-3-70</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ACUTE ABDOMEN</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24-48 HRS</u> |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21. BIRTHPLACE (State or foreign country) <u>SCOTLAND</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-3</u> 19 <u>71</u> to <u>3-5</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>3-5</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 23A. SIGNATURE <u>John Y. Ortiz, M.D.</u> | | |
| 23B. DATE SIGNED <u>3-5-71</u> | | | 23C. PHYSICIAN'S NAME (Type) <u>John Y. Ortiz, M.D.</u> | | 23D. ADDRESS <u>Burgess Funeral Home Balto Md</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u> | | | 24B. DATE <u>3-8-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>St Paul's Cem</u> |
| 24D. LOCATION (City, town, or county) (State) <u>Arcadia Bldg Co Md</u> | | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9, 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Talley, Jr.</u> |
| 25C. FUNERAL DIRECTOR <u>Burgess Funeral Home Balto Md</u> | | | 25D. ADDRESS <u>Burgess Funeral Home Balto Md</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

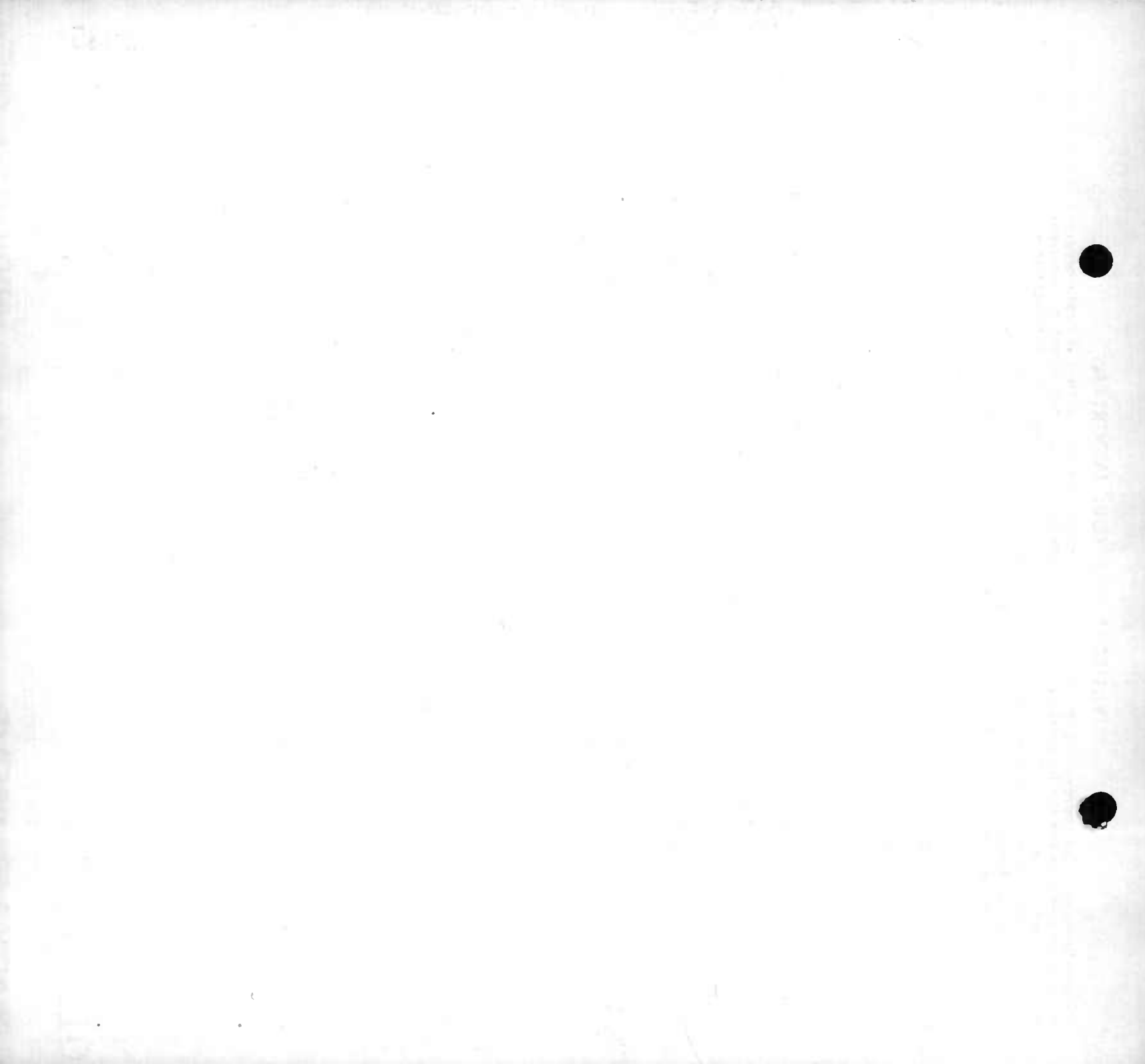
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2324</u> |
|--|------------------------------------|--|---|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) EDITH LEANORE GATCH | | 2. DATE AND HOUR OF DEATH March 4, 1971 <u>7:30</u> p.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 5814 Benton Heights Avenue (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5814 Benton Heights Avenue | | |
| 5. SEX female | 6. RACE caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 20, 1889 | 9. AGE (In years last birthday) 81 If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Charles O. Hossbach | | 14. MOTHER'S MAIDEN NAME Elanora Schueler Same | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 214-40-1683 17. INFORMANT Helen H. Gatch ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH A. IMMEDIATE CAUSE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19. DATE OF OPERATION 3-12-71 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 1950</u> to <u>Mar 4</u> 1971 that (I) (we) last saw the deceased alive on <u>Mar 4</u> 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Dr. Donald W. Mintzer | | 23B. DATE SIGNED 3/5/71 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Donald W. Mintzer | | 23D. ADDRESS 3009 Evergreen Ave., Balto, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 3-8-71 24C. NAME of CEMETERY or CREMATORY Baltimore, Md. - Parkwood 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Balto, Md. ADDRESS | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2325</u> | |
|---|--------------------------------|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>Kirk Edward</u> <u>Baby Boy Harmeyer</u> | | 2. DATE AND HOUR OF DEATH <u>3/4/71</u> <u>10:00 PM.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37</u> <u>Mercy Hospital, Inc.</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2758</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5748 Mapleshill Road #21214</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/4/71</u> | 9. AGE (In years last birthday) <u>1</u> | If Under 1 Yr. Months: <u>1</u> Days: <u>35</u> If Under 24 Hrs. Hours: <u>1</u> Min: <u>35</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>G. Keith Harmeyer</u> | | 14. MOTHER'S MAIDEN NAME <u>Kathleen Austin</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mr G. Keith Harmeyer</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Congenital anomaly</u> <u>(Diaphragmatic hernia, hypoplastic left lung)</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/4</u> 19 <u>71</u> to <u>3/4</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>19</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> <u>M.D.</u> DEGREE | | | | 23B. DATE SIGNED <u>3/5/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>S. EUPEMIO</u> <u>M.D.</u> DEGREE | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/6/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Gardens Of Faith</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc. Baltimore. Md</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2326 | |
|---|-----------|--|------------------|--|--------------------------------|
| <div style="display: flex; justify-content: space-between;"> G-550 71 2326 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| ADA E. GANNON | | 3/6/71 4:15 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 90 Gould Convalesarium | | Md. 2759 | | | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | Gould Convalesarium | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months Days |
| F. | W. | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 6/25/71 | 85 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Md. USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| - | | Sites | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | Thomas Conway 6219 Catalpha Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Pneumonia | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | Uremia | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Carcinoma of the Bladder | | months. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Hypertension - 2° stage. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/22/1970 to 3/6/1971, that (I) (we) last saw the deceased alive on 3/5/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Albert B. Bradley M.D. | | | | 3/6/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Albert B. Bradley Md. | | | | 4900 Belair Rd. Balto. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 3/10/71 | Holy Cross, Brooklyn | | Brooklyn, Md. | |
| 25A. DATE RECD BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 9 1971 | | John E. Bradley, Jr. | | Leonard B. Ruck Inc. | |

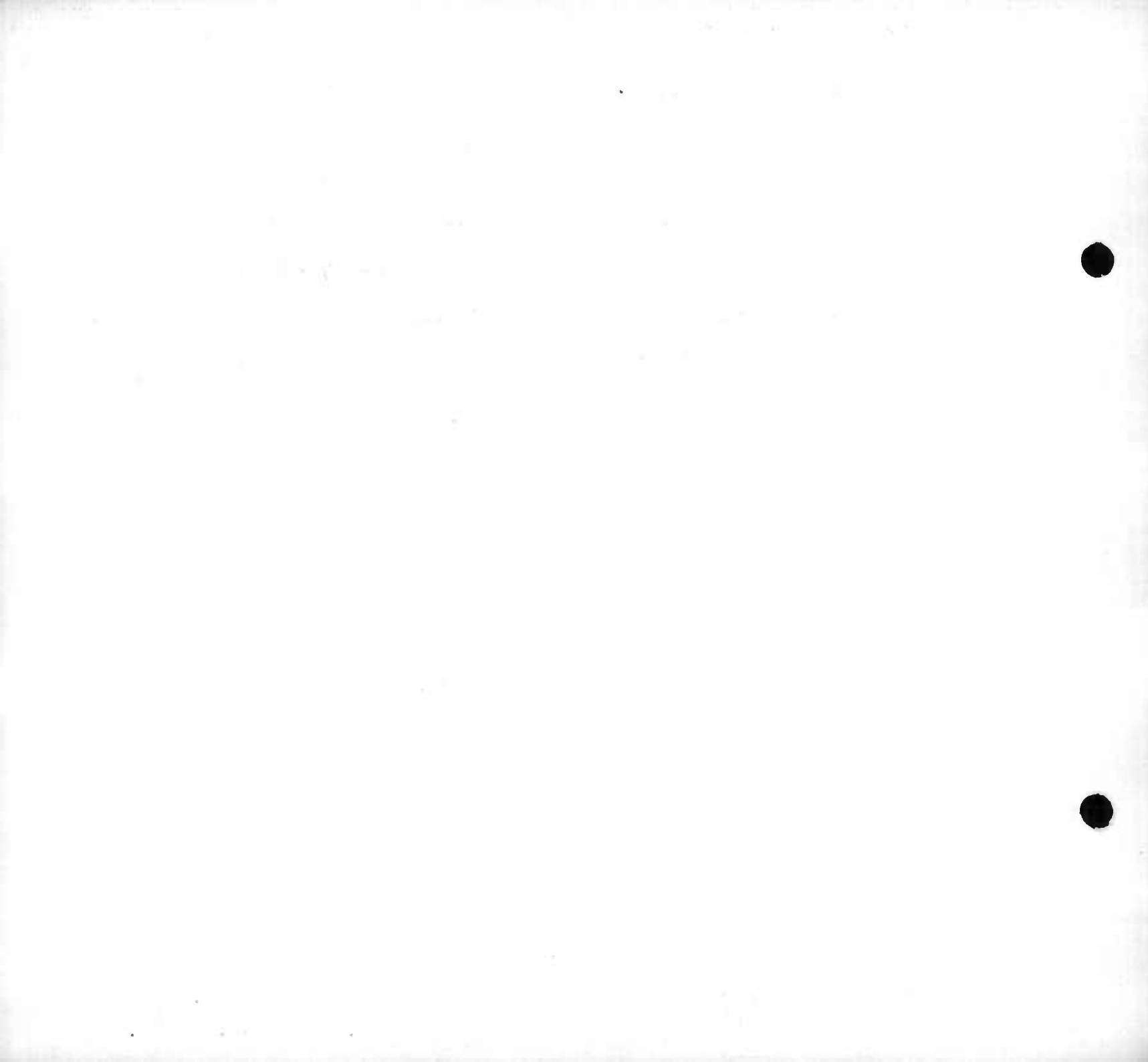
1647 E. Cold Spring L.A.

11/20/70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

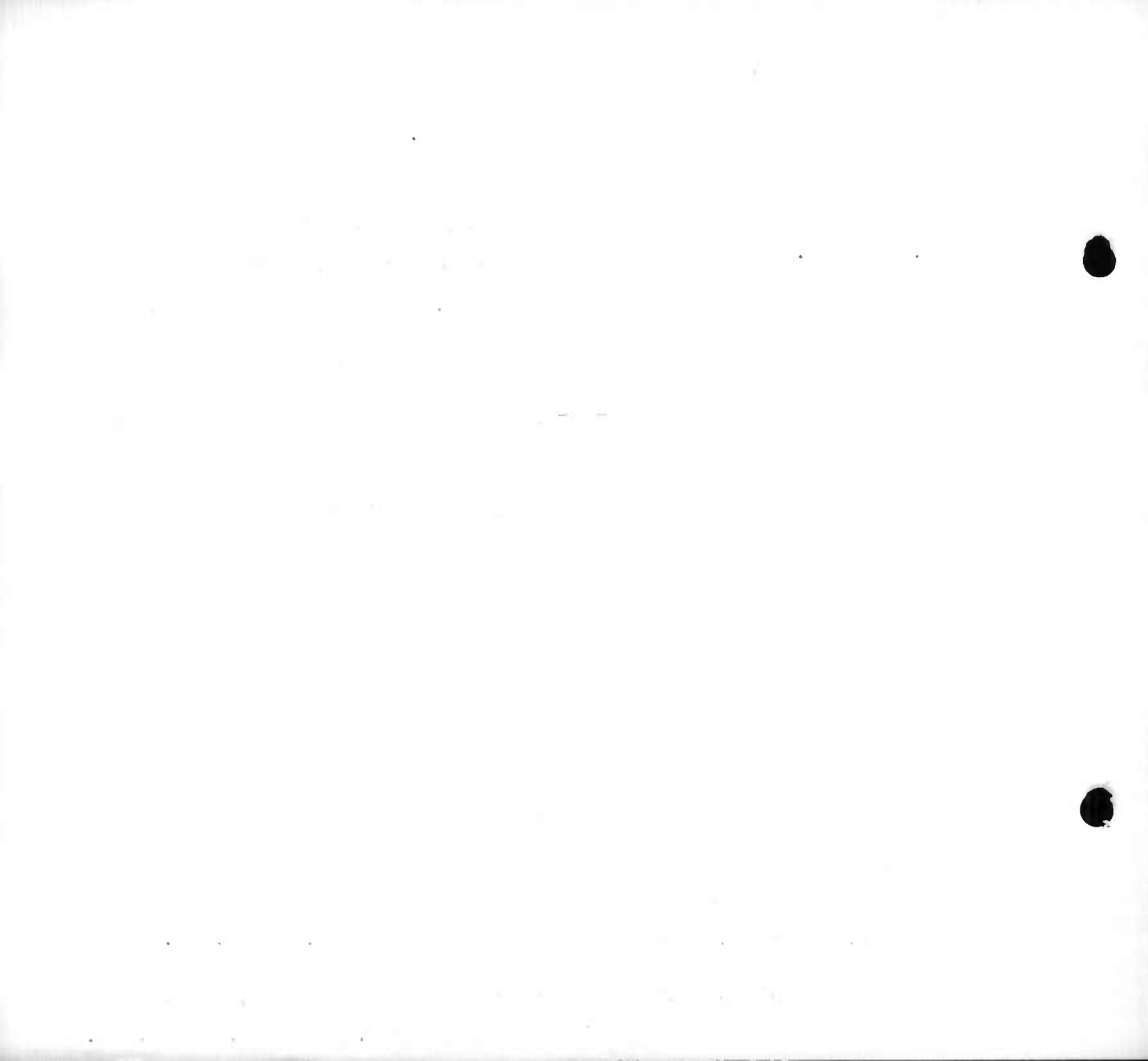
| | | | |
|---|----------------------|---|--|
| <div style="display: flex; justify-content: space-between;"> M-460 71 2327 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> BIRTH NO. REG. NO. 71 2327 </div> | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Miller Norvel R.</u> | | 2. DATE AND HOUR OF DEATH <u>11:20 a.m. 3/7/71</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>45 Good Samaritan Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2735</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3209 Clearview Ave.</u> | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>07-06-03 67 yrs.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas and Electric - Foreman</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 13. FATHER'S NAME <u>Sylvester Miller</u> | | 14. MOTHER'S MAIDEN NAME <u>Lucy Kirks</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>212054595</u> | |
| | | 17. INFORMANT <u>Mrs. Virginia Miller same</u> ADDRESS _____ | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>carcinoma Pa of lung</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. _____ | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: _____ (B) DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>emphysema</u> | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | |
| 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____ | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (mostly medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? _____ | | | |
| 22. I certify that (1) this hospital attended the deceased from <u>3/2</u> 19 <u>71</u> to <u>3/7</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>3/7</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Richard J. Ruck</u> | | 23B. DATE SIGNED <u>3/7/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) _____ | | 23D. ADDRESS _____ | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/11/71</u> | |
| 24C. NAME of CEMETERY or CREMATORY <u>Parkwood</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1971</u> | | 25B. NAME OF REGISTRAR <u>Leonard J. Ruck Inc.</u> | |
| 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u> | | ADDRESS <u>Balto. Md</u> | |



FUNERAL DIRECTOR: IMPORTANT

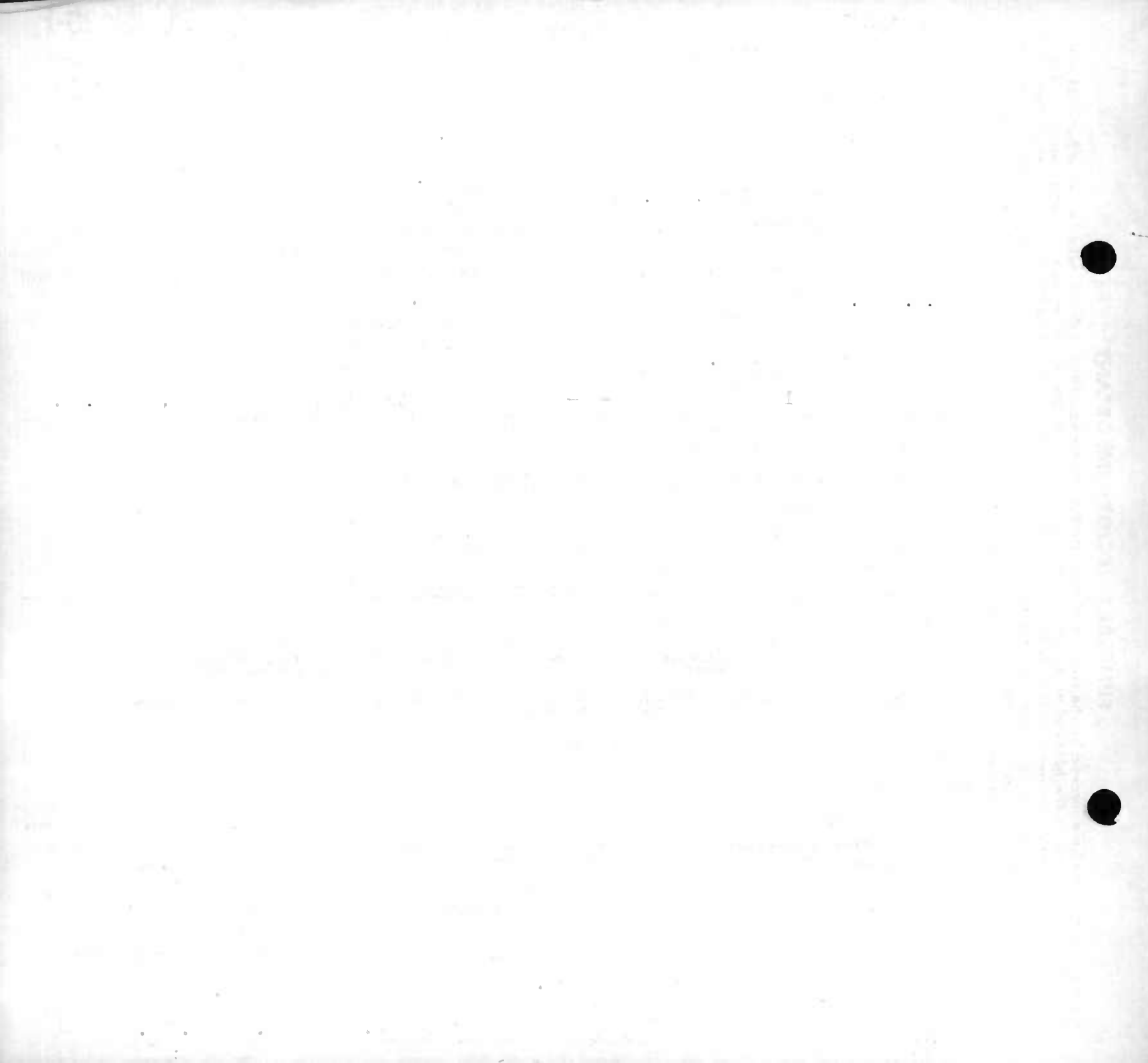
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2328</u> | |
|--|----------------------|---|--------------------------------------|---|---|
| S-340 | | 71 2328 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Nora Stull</u> | | 2. DATE AND HOUR OF DEATH <u>3/7/71</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2768</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00 6133 Parkway Drive</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>6133 Parkway Drive</u> | | | |
| 5. SEX <u>F.</u> | 6. RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>3/24/1912</u> | 9. AGE (In years last birthday) <u>58</u> 59 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Hutzlers</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>? Davis</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>188-05-6948</u> | | 17. INFORMANT ADDRESS <u>Mrs Mary Sachs 2102 Louise Ave</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <u>Chronic Obstructive Pulmonary Disease</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arterio Sclerosis Cardio Vascular Disease</u> | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (A PROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(at the hospital)</u> attended the deceased from <u>June 1967</u> to <u>3/7/71</u> and that (I) <u>(we)</u> last saw the deceased alive on <u>2/23</u> 19 <u>71</u> and that (in my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. <u>FOUND DEAD AT HOME 3/7/71</u> | | | | | |
| 23A. SIGNATURE <u>Thomas L. Worsley</u> | | 23B. DATE SIGNED <u>3/8/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Dr. Thomas L. Worsley</u> | |
| 23D. ADDRESS <u>6505 York Rd. Balto. MD.</u> | | 23E. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. MD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/10/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Leonard J. Ruck</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. MD.</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--------------|---|---|---------------------------------------|---|---|-------------------------------------|---|--|
| 71 2329 | | | | | 71 2329 | | | | |
| BIRTH NO. 5-565 | | | | | CERTIFICATE OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) Daniel Sommerman | | | | | 2. DATE AND HOUR OF DEATH 3/7/71 2:00 a.m. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc. | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 906 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2705 The Alameda | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/22/97 | 9. AGE (in years last birthday) 73 | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Govt. | | | 10B. KIND OF BUSINESS OR INDUSTRY Postoffice | | 13. FATHER'S NAME Daniel Sommerman, Sr. | | | 14. MOTHER'S MAIDEN NAME Phillipina Bachman | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI | | | 16. SOCIAL SECURITY NO. 214-44-5068 | | 17. INFORMANT ADDRESS Albert Streett 170 Stanmore Rd. Balto. Md. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 13-3-8-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Industrial Obstruction (B) Generalized Abdominal Carcinomatosis (C) Carcinoma of Colon APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/6 1971 to 3/7 1971 that (I) (we) last saw the deceased alive on 3/6 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Thanosophon M.D. DEGREE | | | | | 23B. DATE SIGNED 3/7/71 | | | | |
| 23C. PHYSICIAN'S NAME (Type) THANOSOPHON. DEGREE | | | | | 23D. ADDRESS MERCY HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 3/10/71 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Cem. | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | | 25B. NAME OF REGISTRAR Leonard J. Buck Inc. | | | 25C. FUNERAL DIRECTOR ADDRESS Balto. Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

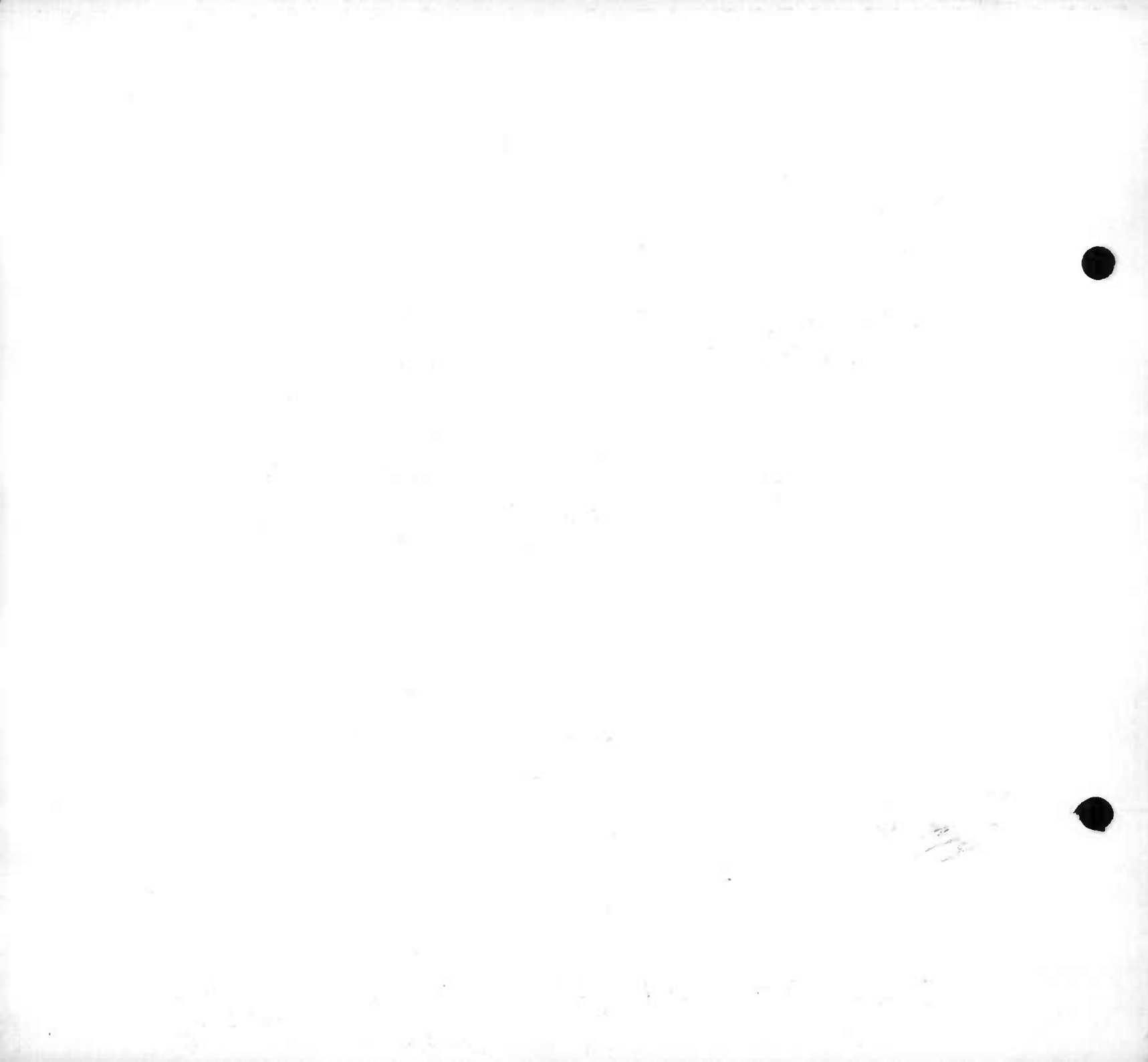
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|---------------------|--|---|---|--|
| B-463 | | 71 2330 | | 71 2330 | |
| <div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) </div> <div> 2. DATE AND HOUR OF DEATH 3/6/71 </div> </div> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION: Midtown Home ADDRESS OR LOCATION: 808 St. Paul St. Balt, Md 21202 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: 1402 C. CITY OR TOWN: Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER: 1427 Druid Hill Ave. | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-25-17 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NO | | 10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | 11. BIRTHPLACE (State or foreign country) S. C. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 248-32-8234 | 17. INFORMANT Sadie Booth - same | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio Respiratory Failure massive Cerebral Hemorrhage (B) Cerebral Infarction, old (C) Gen. Atherosclerosis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 15 1971 to Mar 6 1971, that (I) (we) last saw the deceased alive on Mar 6 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Willard Applefeld | | | | 23B. DATE SIGNED 3/6/71 | |
| 23C. PHYSICIAN'S NAME (Type) Willard Applefeld | | | | 23D. ADDRESS 6615 Rustic Lane Rd | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-11-71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Bailey, M.D. | | 25C. FUNERAL DIRECTOR V. Bailey 1348 Calhoun St. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

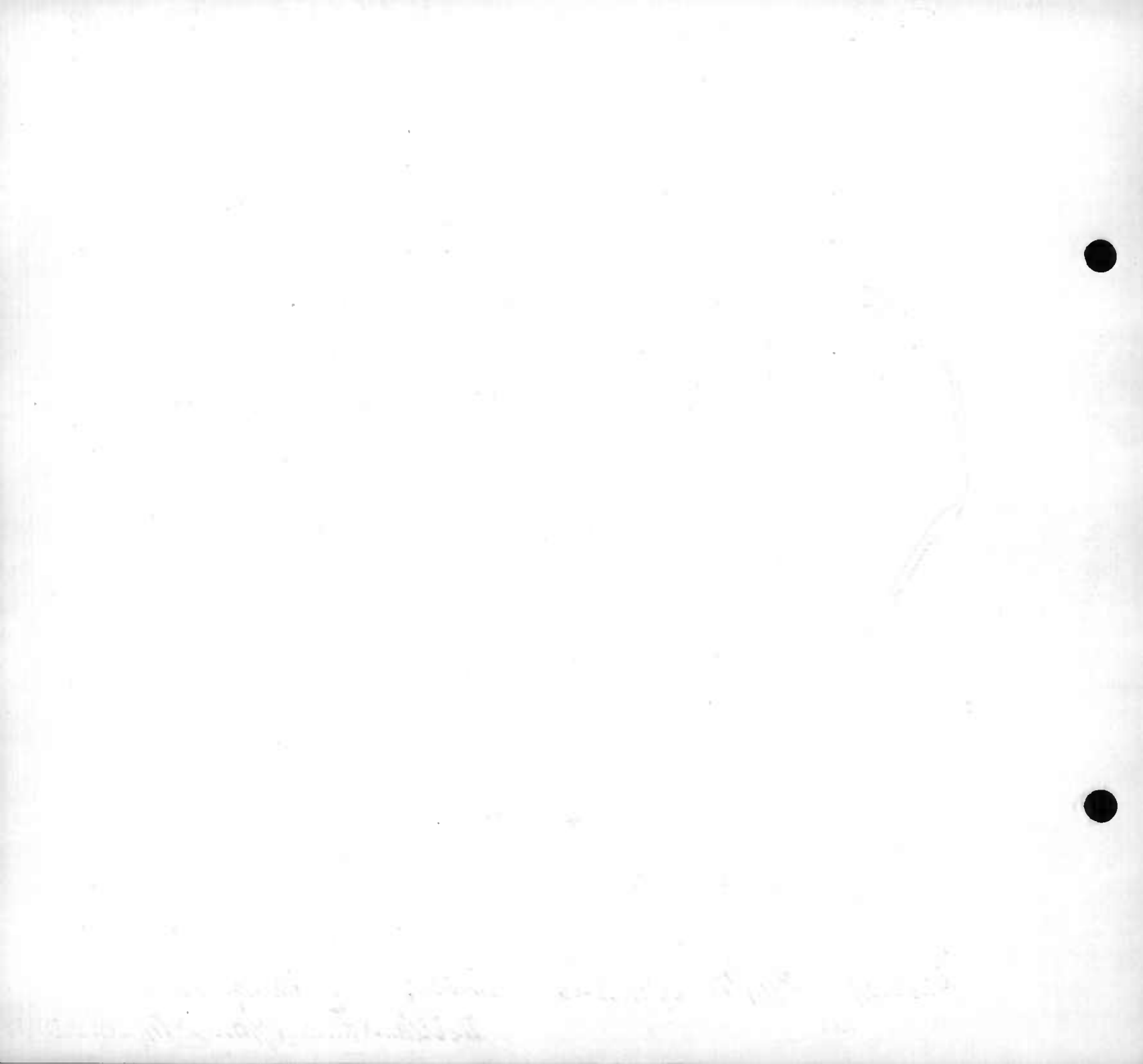
| | | | |
|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> G-426 71 2331 </div> <div style="display: flex; justify-content: space-between;"> BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH </div> | | REG. NO. 71 2331 | |
| BIRTH NO. 1 | | 1. NAME OF DECEASED (Type or Print) McCaig V. Gallagher | |
| 2. DATE AND HOUR OF DEATH Mar 5, 1971 6:40 A.M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Md. 1301 | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1301 | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital | |
| 6. CITY OR TOWN Baltimore | | 7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 8. STREET AND NUMBER 2811 Callow Ave. | | 9. SEX M 10. RACE N 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 12. DATE OF BIRTH 8/12/02 | | 13. AGE (in years last birthday) 68 | |
| 14. BIRTHPLACE (State or foreign country) Md. | | 15. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE | | 17. KIND OF BUSINESS OR INDUSTRY — | |
| 18. FATHER'S NAME Edward Gallagher | | 19. MOTHER'S MAIDEN NAME ANNA | |
| 20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) — | | 21. SOCIAL SECURITY NO. — | |
| 22. INFORMANT Celia Gallagher ADDRESS 2811 Callow Ave | | 23. MRS. Gallagher | |
| 24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH INTRACEREBRAL HEMORRHAGE | | 25. CAUSE OF DEATH INTRACEREBRAL HEMORRHAGE | |
| 26. (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | 27. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE CEREBROVASCULAR DISEASE | |
| 28. ANTECEDENT CAUSES | | 29. (B) DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSION DISEASE | |
| 30. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 31. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 hr. | |
| 32. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 33. (C) | |
| 34. MEDICAL CERTIFICATION | | 35. 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 36. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 37. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 38. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 39. 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 40. 21E. INJURY OCCURRED | | 41. 21F. HOW DID INJURY OCCUR? | |
| 42. 22. I certify that (I) (this hospital) attended the deceased from 3-4 19 71 to 3-5 19 71 that (I) (we) last saw the deceased alive on 3-5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 43. 23A. SIGNATURE R. Kushner M.D. | |
| 44. 23B. DATE SIGNED 3/5/71 | | 45. 23C. PHYSICIAN'S NAME (Type) Dr. Kushner / Tsukamoto | |
| 46. 23D. ADDRESS Maryland General Hosp | | 47. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 48. 24B. DATE 3/10/71 | | 49. 24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PR. | |
| 50. 24D. LOCATION (City, town, or county) (State) Arbutus, Md. | | 51. 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | |
| 52. 25B. NAME OF REGISTRAR John E. Taylor | | 53. 25C. FUNERAL DIRECTOR John E. Taylor ADDRESS 1348 M. Callow ST. (M. Blunt) | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

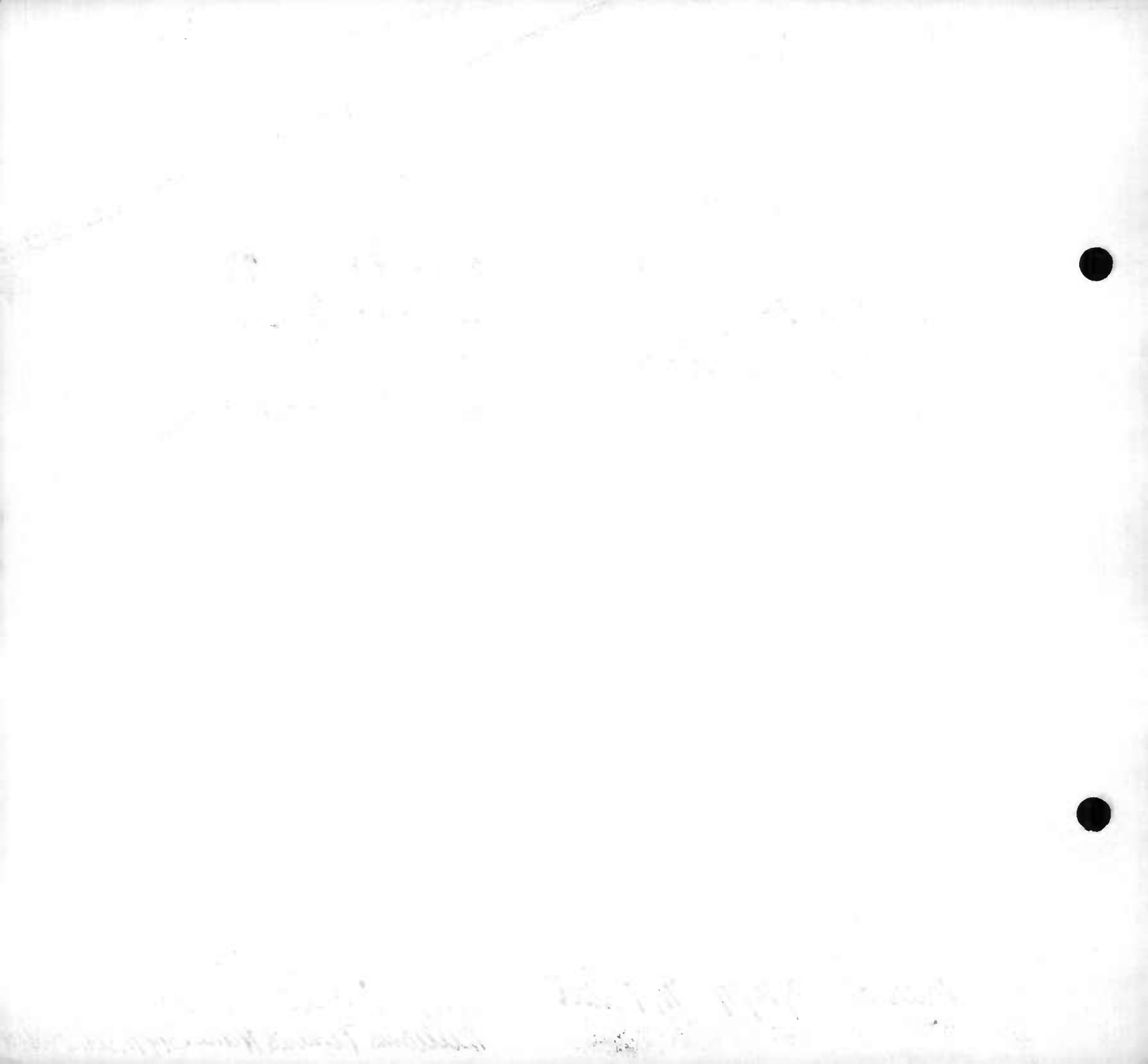
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2332 | |
|--|----------------------------------|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> S-363 71 2332 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Manie N. Stratton | | | 2. DATE AND HOUR OF DEATH March 5, 1971 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001300 W. Saratoga St. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1901 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1300 W. Saratoga St. | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 16, 1901 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Accomac Co. Va. | |
| 13. FATHER'S NAME George E. Kellum | | | 14. MOTHER'S MAIDEN NAME Annie Walker | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Charlie Stratton 1300 W. Saratoga St. | | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH A) IMMEDIATE CAUSE Acute coronary occlusion DUE TO, OR AS A CONSEQUENCE OF: Coronary vascular disease (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 4 years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5-17</u> <u>1967</u> to <u>March 5</u> <u>1971</u>, that (I) last last saw the deceased alive on <u>March 7</u> <u>1971</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>William J. Watts</i> | | | | 23B. DATE SIGNED 3/8/71 | |
| 23C. PHYSICIAN'S NAME (Type) <i>William J. Watts</i> | | | | 23D. ADDRESS <i>5101 Arlington Ave Balto</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/11/71 | | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial | |
| 24D. LOCATION (City, town, or county) (State) Arbutus Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | | |
| 25B. NAME OF REGISTRAR <i>James E. Kelly</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>William J. Watts 3147 Schenck St.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| M-600 71 2333 | | | | | REG. NO. 71 2333 | | | | |
| BIRTH NO. | | | | | 1. NAME OF DECEASED (Type or Print) MARY MARROW | | | | |
| 2. DATE AND HOUR OF DEATH 3/5/71 8:15 A.M. | | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 1601 | | | | | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital | | | | |
| 5. SEX FEMALE | | 6. RACE BLACK | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-12-93 | | 9. AGE (In years last birthday) 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Howard Co. Md | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Samuel Green | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Jesse Craig | | ADDRESS 944 W. Franklin St | | 14. MOTHER'S MAIDEN NAME Mary | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CEREBRO-VASCULAR ACCIDENT (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ESSENTIAL HYPERTENSION (B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC HEART DISEASE (C) ANTICIPATED CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days NOT KNOWN UNKNOWN | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/13 1971 to 3-5 1971 that (I) (we) lost saw the deceased alive on 3-5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Aaron C. Tan, M.D. | | | | | 23B. DATE SIGNED 3-5-71 | | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS PROVIDENT HOSP. BALTIMORE, MD. 21215 | | | | | 23E. FUNERAL DIRECTOR | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3/10/71 | | 24C. NAME OF CEMETERY OF CREMATORY Mt Auburn Cem. Balto. Md. | | 24D. LOCATION (City, town or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | |
| 25A. NAME OF REGISTRAR | | 25B. NAME OF REGISTRAR | | 25C. ADDRESS | | 25D. ADDRESS | | | |



1 51 66 RS
NICHOLS, ANNIE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|---------|---|------------------|---|--|
| N-242 71 2334 | | 71 2334 | | 71 2334 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| ANNIE NICHOLS | | 03-05-71 10:55 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| THE JOHNS HOPKINS HOSPITAL 33 BALTIMORE, MD 21205 | | MARYLAND | | BALTIMORE | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 1821 N. PATTERSON PARK AVE | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| FEMALE | NEGRO | | 05-15-95 | 75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Baltimore, Md | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | 212-56-4609 | | ANNIE JORDAN | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 5 days | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | 4 months | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 13/3/71 | | acute abdomen | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/3 19 71 to 3/5 19 71, that (I) (we) last saw the deceased alive on 3/5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Lawrence J. Koep M.D. | | | | 3/5/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| LAWRENCE J. KOEP | | THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3/12/71 | | Crown Memorial Park | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 9 1971 | | Robert E. Fisher | | 2541 1712 W. North A | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2335

BIRTH NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Robert Hawk | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 3 Day 7 Year 71 Hour 2:25 p.m. Estimated <input type="checkbox"/> | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION, ADDRESS OR ROOM NO. St. Agnes Hospital 4-13-71 | | | | 3. DATE PRONOUNCED DEAD Month 3 Day 7 Year 71 Hour 2:25 p.m. | | | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1608 | | | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 6. SEX male | | 7. RACE White | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER 921 N. Augusta Avenue | |
| 9. DATE OF BIRTH Oct. 1, 1916 | | 10. AGE (In years last birthday) 54 | | 11. BIRTHPLACE (State or foreign country) Pg. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Bethlehem Steel | | | | 14B. KIND OF BUSINESS OR INDUSTRY | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II | | | | 17. SOCIAL SECURITY NO. | | 15. MOTHER'S MAIDEN NAME unknown | |
| 19. 4319 | | | | 18. INFORMANT ADDRESS Beatrice Hawk - 921 Augusta Ave. | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 2 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22F. HOW DID INJURY OCCUR? | | | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Russell S. Fisher, M.D. | | | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | DATE SIGNED 3/8/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-12-71 | | 24C. NAME of CEMETERY or CREMATORY Arboretum Mem. Park | | 24D. LOCATION (City, town, or county) (State) Arboretum, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS Elbert Funeral Home 11297 Carroll St. | | | |

Letter from M.E.'s office 4-13-71 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|--|----------------------------|--|----------------------------|--|--|
| M-200 | | 71 2336 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2336 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) VIRGIL MOCK | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH 3/7/71 8:40 P. M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MD. BALTIMORE CITY 2716 | | C. CITY OR TOWN BALTIMORE | |
| SINAI HOSP. OF BALT., INC. | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 3509 WOODLAND AVE. | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/3/80 | 9. AGE (In years last birthday) 96 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) N. Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ? | | Mock | | 14. MOTHER'S MAIDEN NAME Margaret | | ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Rev. Belvino Mock-3509 Woodland Ave | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH CHRONIC BRAIN DAMAGE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROSIS OF BLOOD VESSELS OF BRAIN (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | INFECTED DECUBITUS ULCERS | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 1, 1971 to MARCH 7, 1971 that (I) (we) last saw the deceased alive on MARCH 7, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Jan Sunshine M.D. | | | | 23B. DATE SIGNED 3/7/71 | | 23C. PHYSICIAN'S NAME (Type) IAN SUNSHINE | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Removal | | 24B. DATE 3-9-71 | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) High Point, N. Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Bright Funeral Home | | ADDRESS 1129 N. Carolina | |



W-452

71 2337

BALTIMORE CITY HEALTH DEPARTMENT

71 2337

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) LILLIAN WILLIAMS | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 5, 1971 5:05 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 5, 1971 5:05 P. M. | |
| 6. SEX Female | | 7. RACE Negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH April 2-1930 | | | | 10. AGE (In years last birthday) 40+ If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore Md | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work, date during most of working life, even if retired) | | | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 17. SOCIAL SECURITY NO. 213-30-5116 | |
| 18. INFORMANT Dois Lee | | | | ADDRESS | |
| 19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| 20A. DATE OF OPERATION 2 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 3/6/71 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-10-71 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Court | |
| 24D. LOCATION (City, town, or county) (State) Arbutus Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR Corbin 1000 Cranberry Ln | |
| 25D. ADDRESS | | | | | |

Letter from M.E.'s office

3-26-71 M.H.

VALLEY FORGE

B-653

71 2338 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2338

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) WILLIE BRYANT | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 3 4 1971 5:03 p.m. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1301 | |
| 9. DATE OF BIRTH Feb 19, 1932 | | 10. AGE (In years lost birthday) 38 | |
| 11. BIRTHPLACE (State or foreign country) Raleigh N. Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Willie H Bryant | | 14. MOTHER'S MAIDEN NAME Louise Wiggins | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 16. KIND OF BUSINESS OR INDUSTRY | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 18. SOCIAL SECURITY NO. 244-42-0940 | |
| 19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (Approx.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 3/5/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-10-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt Arden Cal | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, R.A. | |
| 25C. FUNERAL DIRECTOR Longman 1000 Braniff | | ADDRESS | |

Letter from M.E.'s office

5-3-71

M.H.

VALLEY FORCE

25 PAGES CONTENT

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11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|-------------------------|---|--|
| B-650 71 2339 CERTIFICATE OF DEATH X REG. NO. 71 2339 | | | |
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) STEPHEN M. ERWIN | | 2. DATE AND HOUR OF DEATH 3/5/71 8:40 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSPITAL INC 301 ST. PAUL PR 202 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY PRINCE GEORGES 5200 SEVERNA PARK C. CITY OR TOWN SEVERNA PARK D. INSIDE CITY LIMITS? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 477 LONDON LA., SEVERNA PARK | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/15/67 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAD (STUDENT) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 3 yrs If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) OHIO | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME RICHARD J. ERWIN | | 14. MOTHER'S MAIDEN NAME JEANNE ANN WANKLER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT PARENTS AS ABOVE | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 347.91 REYE'S SYNDROME 3 DAYS ANTECEDENT CAUSES (ADDITIONAL EXCEPTALOGY WITH FATTY CHANGES TO THE VISCERA - LIVER, etc.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/4/71 19 to 3/5/71 19 that (I) (we) last saw the deceased alive on 3/5/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Emilio P. Gonzalez | | 23B. DATE SIGNED 3/6/71 | |
| 23C. PHYSICIAN'S NAME (Type) Emilio P. Gonzalez, MD. | | 23D. ADDRESS 301 ST. PAUL PR., PRINCE GEORGES, MD. 21202 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/71 | |
| 24C. NAME of CEMETERY or CREMATORY Calvary Cem | | 24D. LOCATION (City, town, or county) (State) Springfield Ohio | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1971 | | 25B. NAME OF REGISTRAR Robert S. Barranco | |
| 25C. FUNERAL DIRECTOR Robert S. Barranco | | 25D. ADDRESS 10111 Seabreeze Rd., Severna Park, MD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | BALTIMORE CITY HEALTH DEPARTMENT | |
|---|--|--|--|---|--|--|--|
| H-300 71 2340 | | | | CERTIFICATE OF DEATH | | R. G. NO. 71 2340 | |
| 1. NAME OF DECEASED (Type or Print) <i>Joseph H. Hite</i> | | | | 2. DATE AND HOUR OF DEATH <i>3-8-71 11:30 A.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION <i>435 South Balt Gen. Hosp.</i> 3-22-71 IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>RT 1</i> B. COUNTY <i>Box 3886</i> 5200 | | | |
| 5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <i>Aug 31 1913</i> | | 9. AGE (In years last birthday) <i>57</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Steel Co</i> | | 11. BIRTHPLACE (State or foreign country) <i>W. Va.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | 13. FATHER'S NAME <i>Charles Hite</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Effie Hite</i> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>No</i> | | | |
| 16. SOCIAL SECURITY NO. <i>236-74-4679</i> | | | | 17. INFORMANT ADDRESS | | | |
| 18. <i>492X</i> I SS#236-14-2619 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostemia, etc. It means the disease, injury or complication which caused death.) <i>Respiratory Failure</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Emphysema</i> | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>2-1</i> 19 <i>71</i> to <i>3-5</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>2-5</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE <i>Daniel M. Howell M.D.</i> DEGREE | |
| 23B. DATE SIGNED <i>11:30 A.M.</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Daniel M. Howell</i> DEGREE | | 23D. ADDRESS <i>South Balt. Gen Hosp</i> | | 23E. FUNERAL DIRECTOR <i>Robert E. Barber, R.D.</i> ADDRESS | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE <i>3/9/71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>West Pleasant Cem</i> | | 24D. LOCATION (City, town, or county) (State) <i>Martinsburg W. Va.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 9 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Barber, R.D.</i> | | 25C. FUNERAL DIRECTOR <i>Robert E. Barber, R.D.</i> | | 25D. ADDRESS <i>Alverna Ph. M.</i> | |

V.S. 153

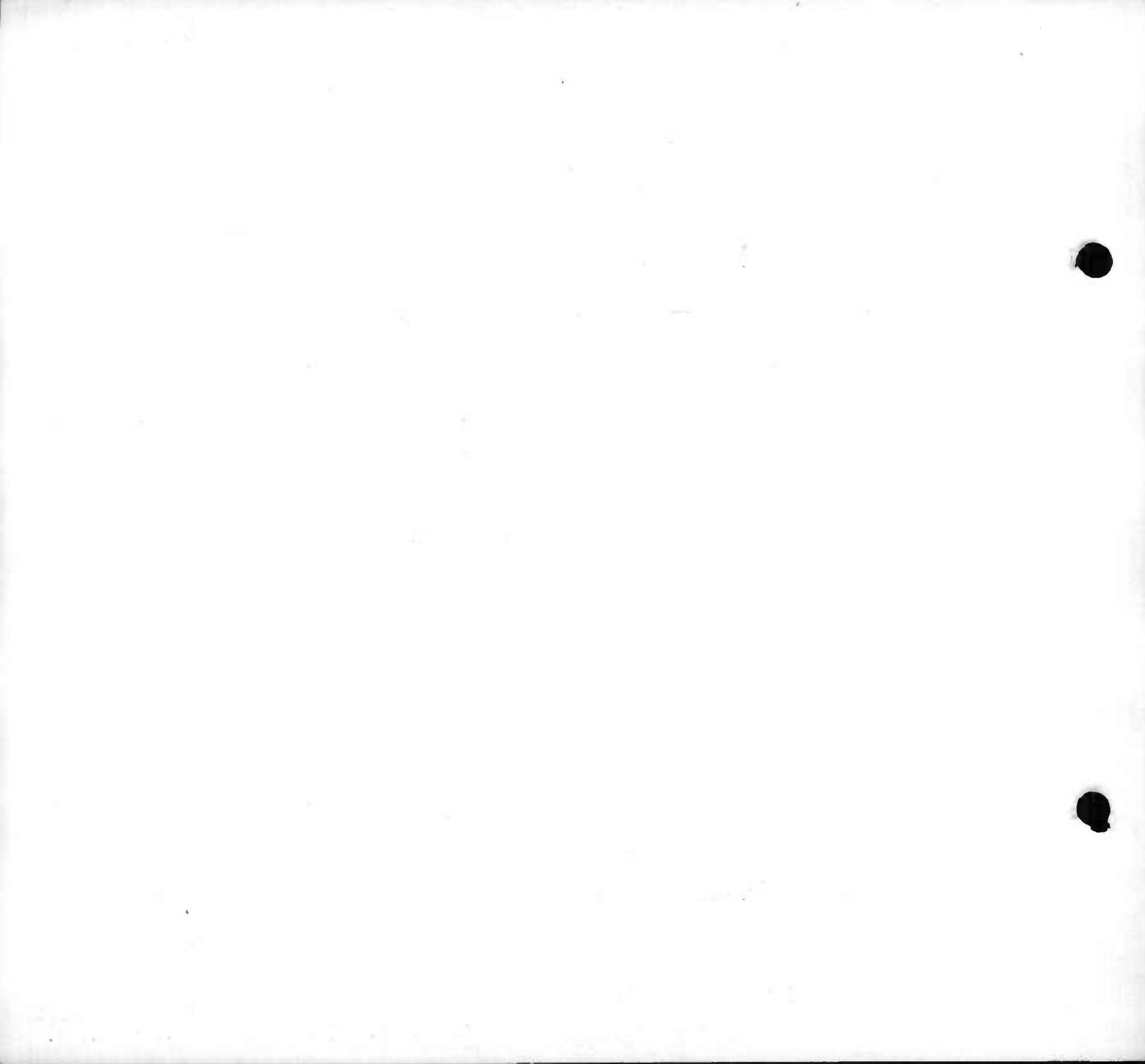
3-22-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | X | |
|--|--|--|--|
| 71 2341 | | 71 2341 | |
| BIRTH NO. (8) | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <u>Ada Klein</u> | | 2. DATE AND HOUR OF DEATH <u>3-7-71</u> <u>2:45 P.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bon Secours Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>BALTO.</u> B. COUNTY <u>MARYLAND</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u> | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER <u>118 Malbrook Rd</u> <u>5300</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 9. AGE (In years last birthday) <u>85</u> | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>--</u> | | 11. BIRTHPLACE (State or foreign country) <u>England</u> | |
| 13. FATHER'S NAME <u>William Barrett</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 14. MOTHER'S MAIDEN NAME <u>Emma Rawlinson</u> | |
| 16. SOCIAL SECURITY NO. <u>212-03-37820</u> | | 17. INFORMANT <u>Mrs. John Keepers</u> ADDRESS <u>21207</u> | |
| 18. <u>4/10/71</u> CAUSE OF DEATH | | 18. <u>Cardiac Arrest</u> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) <u>Heart</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 <u>71</u> to <u>3/7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>James Nolan</u> M.D. | | 23B. DATE SIGNED <u>3/1/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>J J NOLAN</u> | | 23D. ADDRESS <u>Baltimore Md 21229</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/9/71</u> | |
| 24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Kelly</u> | |
| 25C. FUNERAL DIRECTOR <u>Witzke, Inc.</u> | | 25D. ADDRESS <u>1630 Edmondson Av., Balto., Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 71 2342 | |
|---|--|---|--|--|---|---|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Fones, Cornelia | | | | 2. DATE AND HOUR OF DEATH 3/7/71 3:55 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 14 Union Memorial Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 2644 | | | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 6000 Moravia Road | | | |
| 5. SEX F | 6. RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-11-93 | 9. AGE (In years last birthday) 77 | 10. Under 1 Yr. Months: Days: | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) ITALY | |
| 12. CITIZEN OF WHAT COUNTRY? American | | | | | | | |
| 13. FATHER'S NAME Salvatore Cuom | | | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Chert | |
| | | | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH septicemia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: pulmonary embolism | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-2 19 71 to 3-7 19 71 that (I) (we) last saw the deceased alive on 3/7 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE I. Chert | | | | 23B. DATE SIGNED 3/7/71 | | 23C. PHYSICIAN'S NAME (Type) ISSAM E CHEIKH | |
| | | | | 23D. ADDRESS Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/71 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Talbot | | 25C. FUNERAL DIRECTOR George A. Zarnow | | ADDRESS 263 S. Lexington St | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT 71 2343 W-300 | | | | | | | | | | |
|---|--|-------------------------|---|---|--|--|---|--|---|--|
| 71 2343 REG. NO. | | | | | | | | | | |
| BIRTH NO. | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) WHITE, WHITEFORD | | | | | 2. DATE AND HOUR OF DEATH March 5, 71 1 8 p. M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1201 | | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | C. CITY OR TOWN/ Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | E. STREET AND NUMBER 221 RIDGEMEDE ROAD | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-15-02 | | 9. AGE (In years lost birthday) 68 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Proprietor Tobacco Business | | | | 10B. KIND OF BUSINESS OR INDUSTRY Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? American | | |
| 13. FATHER'S NAME XXXXXXXXXX Joseph M. White | | | | | 14. MOTHER'S MAIDEN NAME XXXXXXXXXX Julia Eleanor Ford | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 212-16-3950 A | | 17. INFORMANT Mrs. Thelma White | | | | |
| | | | | ADDRESS same | | | | | | |
| 18. 1621 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinomatosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cancer of the lung (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month. | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 1 19 71 to March 5 19 71 that (I) (we) last saw the deceased alive on March 5 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Tohru Ohe | | | | | 23B. DATE SIGNED March 5, 71 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Tohru OHE | | | | | 23D. ADDRESS Union Memorial Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE March 8, 1971 | | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | 25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. | | | ADDRESS Baltimore Md. | |



FUNERAL DIRECTOR: IMPORTANT

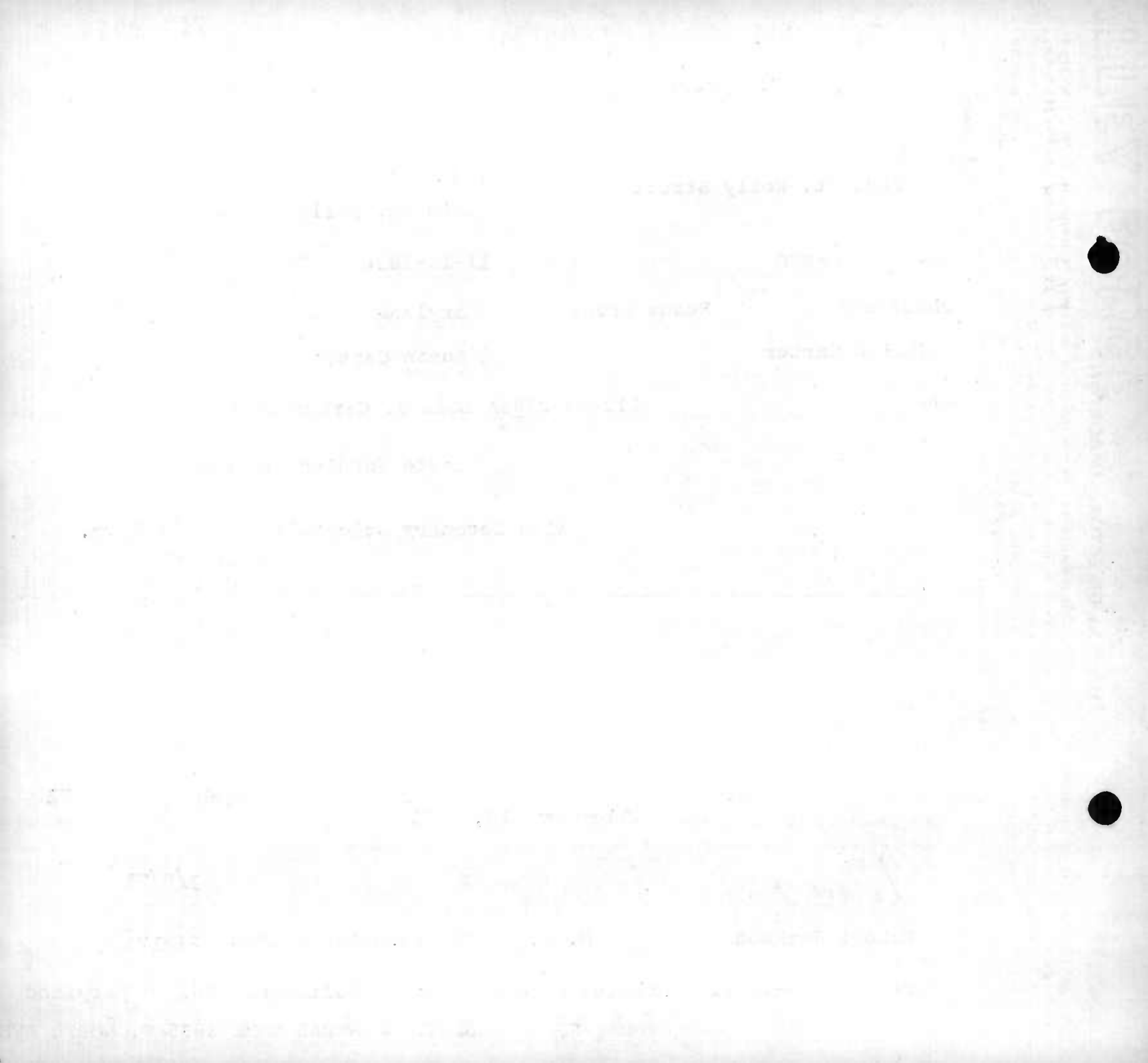
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 2344

| | | | |
|--|-------------------------|---|--|
| BIRTH NO. <u>71 2344</u> | | 2. DATE AND HOUR OF DEATH <u>March 8, 1971</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>Charles W. Carter</u> | | M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2805 Mt. Holly Street</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1509</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2805 Mt. Holly Street</u> | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-19-1896</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>chauffeur</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Reads Drugs</u> | 9. AGE (In years last birthday) <u>74</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Willis Carter</u> | | 14. MOTHER'S MAIDEN NAME <u>Susan Carter</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-03-2798A</u> | |
| 17. INFORMANT <u>Lois J. Carter</u> | | ADDRESS <u>2805 Mt. Holly Street</u> | |
| 18. <u>412.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Cardiac Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>With Coronary Sclerosis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1966</u> to <u>March 1971</u> , that (I) (we) last saw the deceased alive on <u>February 19, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Robert Jackson</u> | | 23B. DATE SIGNED <u>3/9/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Robert Jackson</u> | | 23D. ADDRESS <u>M. D. 600 Arlington Avenue 21217</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-11-71</u> | |
| 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9, 1971</u> | | 25B. NAME OF REGISTRAR <u>380 E. Jackson St.</u> | |
| 25C. FUNERAL DIRECTOR <u>OUTTER FUNERAL HOME</u> | | ADDRESS <u>3035 W. NORTH AVE</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2345</u> | |
|--|--|--|--|---|--|
| BIRTH NO. <u>71 2345</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Kellam, Marie L</u> | | | 2. DATE AND HOUR OF DEATH <u>3-7-71</u> <u>12:35 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles General Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1601</u> | | |
| 5. SEX <u>Female</u> 6. RACE <u>Negro</u> | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 8. DATE OF BIRTH <u>5/20/1903</u> | | | 9. AGE in years lost birthday <u>67</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Holton, Thomas</u> | | | 14. MOTHER'S MAIDEN NAME <u>Liza ?</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>214-24-6086</u> | | |
| 17. INFORMANT <u>Robert Hall</u> | | | ADDRESS <u>1210 Smithson Street</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Gram Negative Shock</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral Vascular Accident</u> | | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>8 mo.</u> | | |
| (C) <u>Generalized Arteriosclerosis</u> | | | <u>unknown.</u> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Hypertension, Diabetes, Tuberculosis</u> | | | <u>unknown</u> | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-7</u> 19 <u>71</u> to <u>3-7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3-7</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Richard L. Heppner M.D.</u> DEGREE | | | | 23B. DATE SIGNED <u>3/7/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Richard L. Heppner</u> MD. DEGREE | | | | 23D. ADDRESS <u>2724 No. Charles St. Balt. Md.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-10-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore</u> | | 24E. STATE (City, town, or county) <u>Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>NUPTER FUNERAL HOME 3035 W. NORTH AVE.</u> | |

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21/11/11

FUNERAL DIRECTOR: IMPORTANT

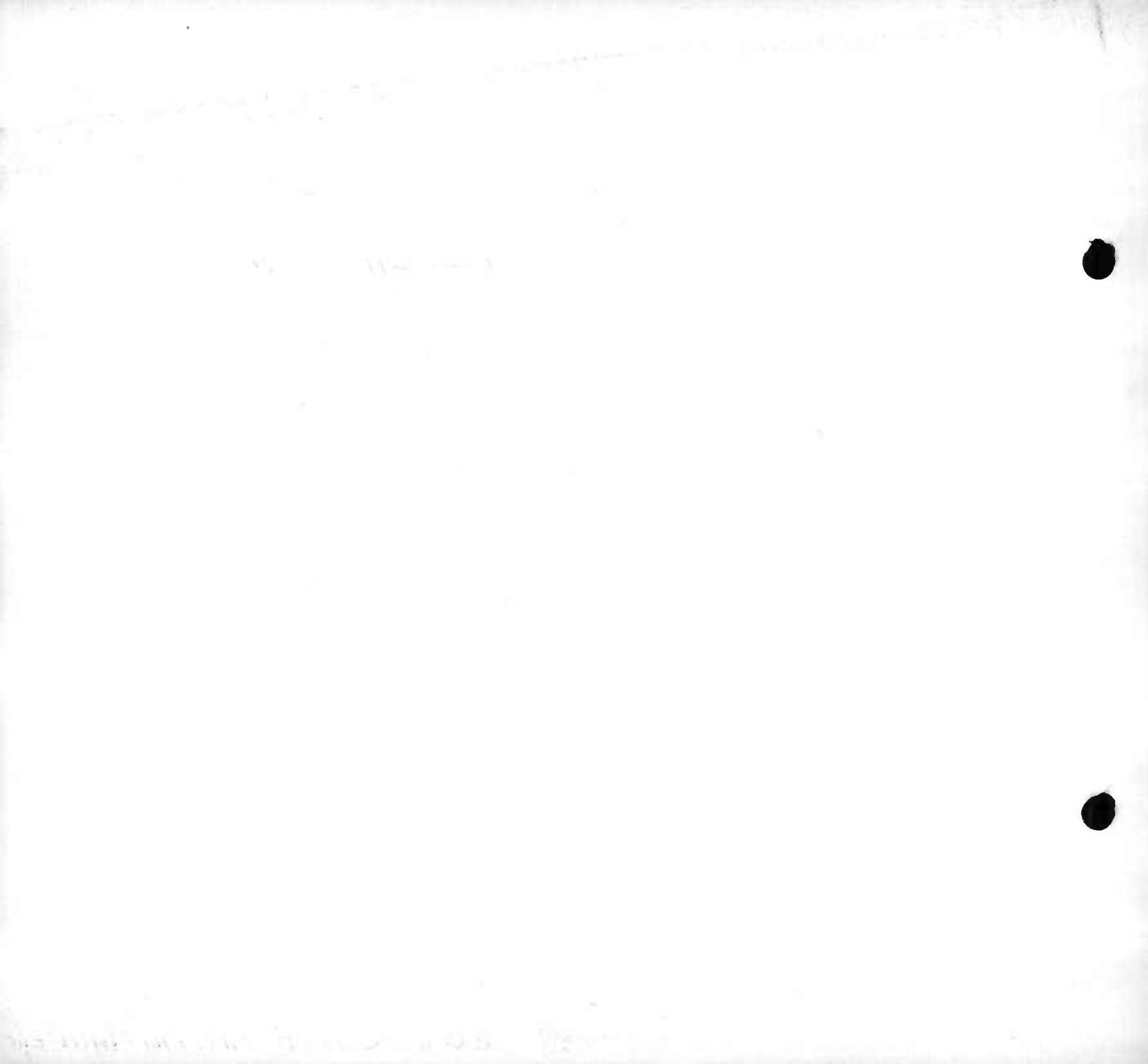
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|----------------------------------|--|------------------------|--|
| BIRTH NO. 71 2346 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 71 2346 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Williams, Rosa | | |
| 2. DATE AND HOUR OF DEATH 3-8-71 | | | M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3141 SEQUOIA AVE BALTO, MD. 21215 | | | A. STATE B. COUNTY MARYLAND #15 1511 | | |
| 5. SEX F | | | 6. RACE N | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | 8. DATE OF BIRTH 4-19-25 | | |
| 9. AGE (In years lost birthday) 45 | | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | | 10B. KIND OF BUSINESS OR INDUSTRY CANNING CO. | | |
| 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Lonnie Colson | | | 14. MOTHER'S MAIDEN NAME Bessie Colson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 26-05-7810 | | |
| 17. INFORMANT George Williams | | | ADDRESS ME P. RECORDS 3141-SEQUOIA | | |
| 18. 183.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CA OVARY & WIDESPREAD METASTASIS | | | INTERVAL BETWEEN ONSET AND DEATH 9 MOS | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-2-7 1970 to MARCH 4 1971 that (I) (we) last saw the deceased alive on MARCH 4 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jacinto V. de Borsja | | | 23B. DATE SIGNED March 9, 1971 | | |
| 23C. PHYSICIAN'S NAME (Type) JACINTO V. DE BORSJA M.D. | | | 23D. ADDRESS SINAI HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 3-12-71 | | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Park | | | 24D. LOCATION Baltimore Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | |
| 25C. FUNERAL DIRECTOR | | | 25D. ADDRESS Morton Dyett F.H. 1701-LAUREL | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>71 2347</u> | |
|--|--|---|--|
| 71 2347 CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>ALICE B. WILLIS</u> | | <u>MARCH 8, 1971</u> <u>15:20 A</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>35 CHURCH HOME & HOSPITAL</u> <u>BALTIMORE, MD. 21231</u> | | A. STATE <u>1509</u> B. COUNTY | |
| 5. SEX <u>F</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | |
| 6. RACE <u>N</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER <u>2101 LYNDBURST AVE.</u> | |
| 8. DATE OF BIRTH <u>12-16-11</u> | | 9. AGE (in years last birthday) <u>60</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAID</u> | | 11. BIRTHPLACE (State or foreign country) <u>S. CAROLINA</u> | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>BELTON BOLER</u> | | 14. MOTHER'S MAIDEN NAME <u>SALLIE S. LAUDNUM</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>214-26-5328</u> | |
| 17. INFORMANT <u>W. MANIAGO M.D. CHURCH HOME HOSP</u> | | ADDRESS <u>BALTIMORE</u> | |
| 18. <u>204.1</u> CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Chronic lymphatic leukemia</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) <u>Fluid & electrolyte</u> (C) <u>unbalance</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>W. Maniago, M.D.</u> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>WILM A. P. MANIAGO M.D.</u> | | 23D. ADDRESS <u>CHURCH HOME & HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-13-71</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>WESTERN STAR</u> | | 24D. LOCATION (City, town, or county) (State) <u>CATONSVILLE, MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u> | |
| 25C. FUNERAL DIRECTOR <u>Morton Glyett F.H.</u> | | ADDRESS <u>1701 LAUREL</u> | |



I1001

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 71 2348 REG. NO. 71 2348

| | | | | | | | |
|--|-------------------------|---|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) (Archie) ARCSIE O. IVY | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 6, 1971 Hour 5:30 A.M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTO. GENERAL HOSPITAL | | | | 3. DATE PRONOUNCED DEAD Month Day Year March 6, 1971 Hour 5:30 A.M. | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2562 | | | |
| 6. SEX Male | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH 10. AGE (In years last birthday) 1 1/2 | | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | E. STREET AND NUMBER 714 Reedbird Avenue | | | |
| 11. BIRTHPLACE (State or foreign country) Macon, Georgia | | 12. CITIZEN OF U. S. A. | | 13. FATHER'S NAME Autrey Ivy | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Bertha Hawkins | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT Autrey Ivy 741 Reedbird Balto, Md. 21225 | | | |
| 19. E8871X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH Brain injury (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Home | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 714 Reedbird Avenue 2562 | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 2-28-71 7:00 P. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Apparently fell at home | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate (M.D.) EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/6/71 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-12-71 | | 24C. NAME of CEMETERY or CREMATORY Macon, Georgia Ceme. | | 24D. LOCATION (City, town, or county) (State) Macon, Georgia | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR Morton & Dyett F. H. | | ADDRESS Baltimore, Md. 21217 1701 Laurens St. | |

March, 1944

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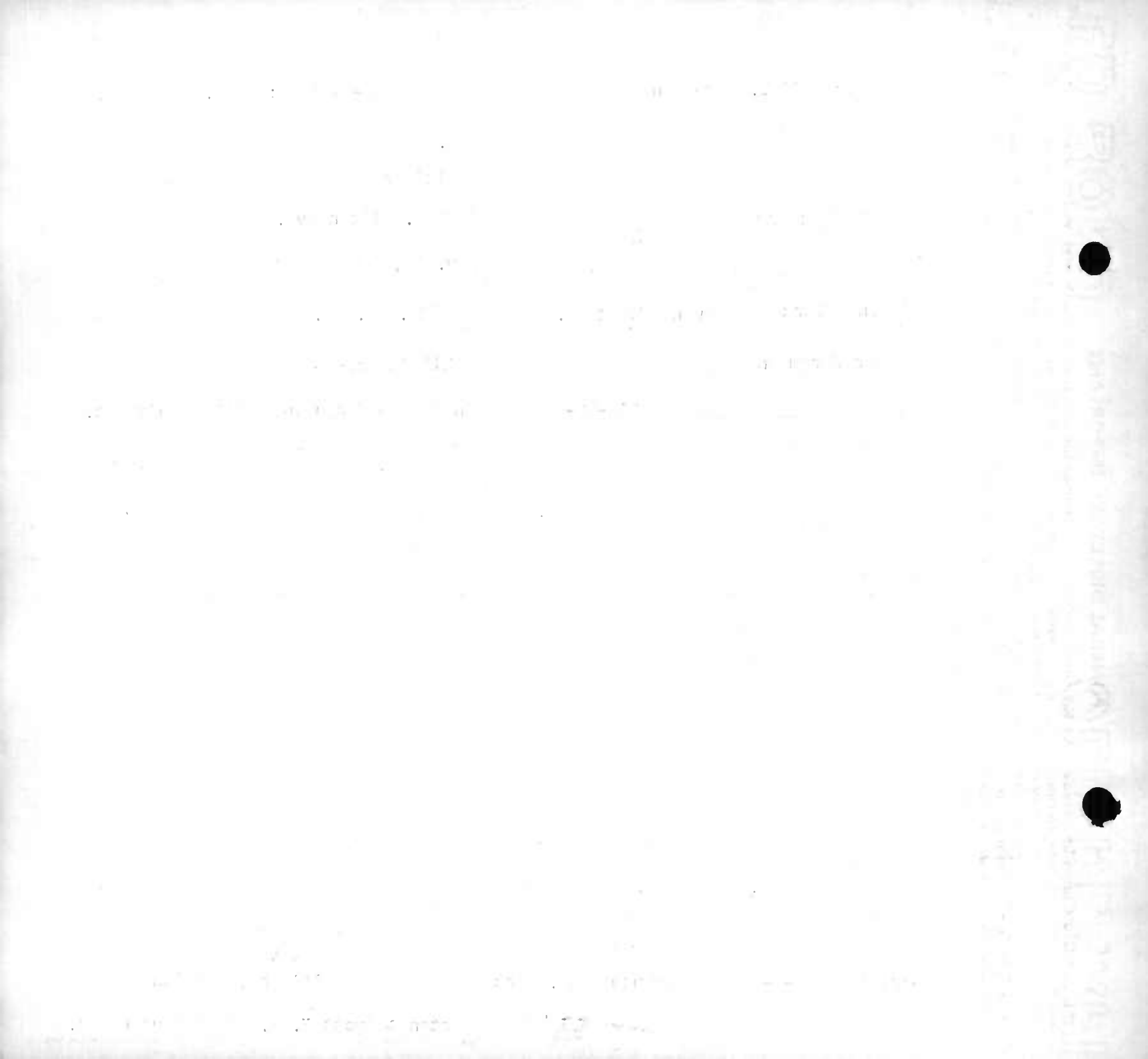
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

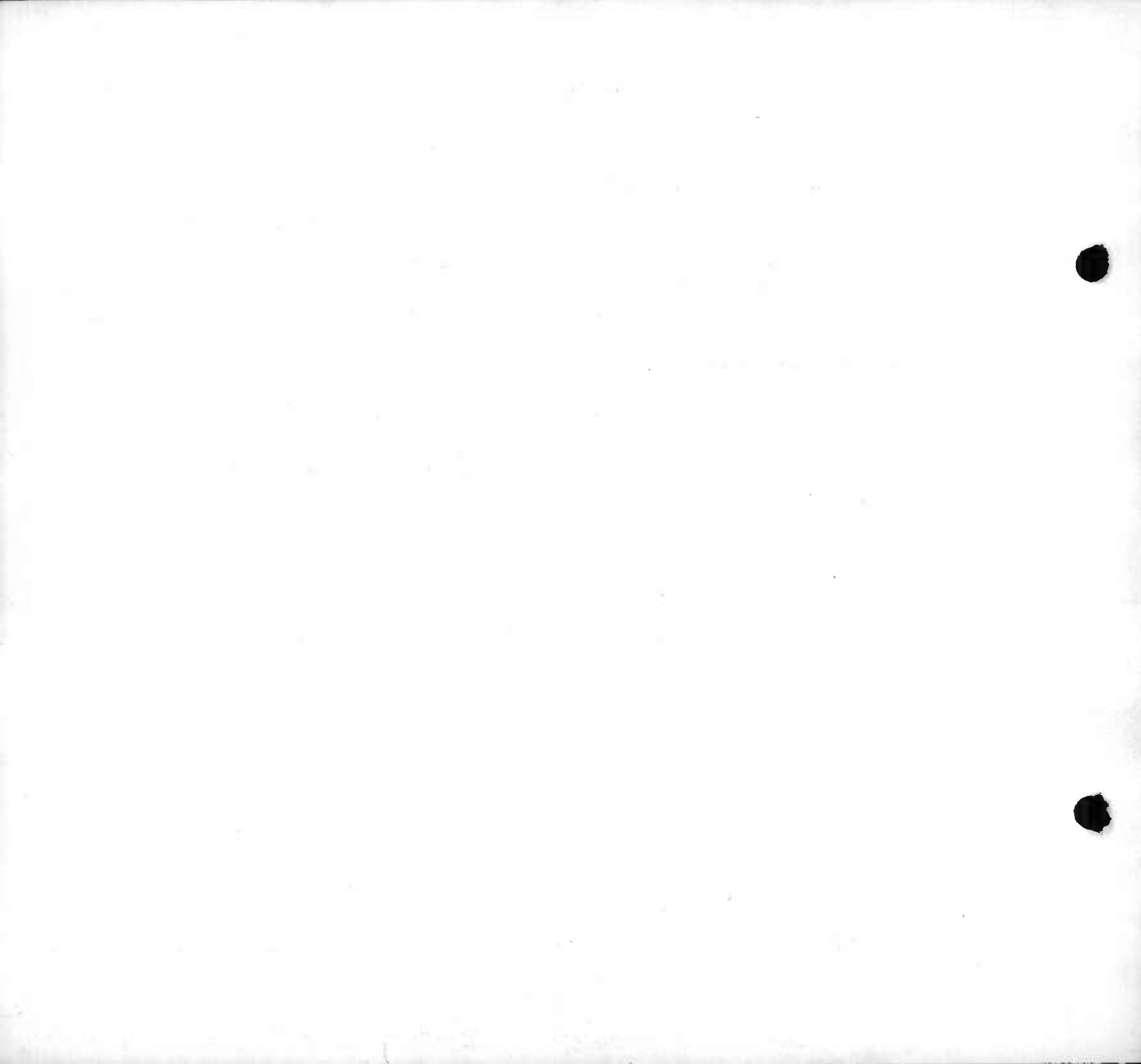
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2349</u> | |
|--|------------------|---|--|--|---|
| BIRTH NO. <u>71 2349</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Marshall L. Ferguson</u> | | | 2. DATE AND HOUR OF DEATH <u>3-5-71 6:00 pm.</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>5773 Eastbury</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>802</u> | | |
| | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>1603 N. Milton Ave.</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 19, 1928</u> | 9. AGE (In years last birthday) <u>42</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Owens Yacht Co.</u> | 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Oscar Ferguson</u> | | | 14. MOTHER'S MAIDEN NAME <u>Lillie Brisco</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> | | | 16. SOCIAL SECURITY NO. <u>215-22-6100</u> | | 17. INFORMANT <u>Minnie Mae Ferguson</u> ADDRESS <u>733 Asquith St.</u> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Shock</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Gastrointestinal Hemorrhage</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>2 Days</u> (C) _____ | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-5-71</u> to <u>Same Date of Death</u> that (I) (we) last saw the deceased alive on <u>3-5-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Eugene H. Owens M.D.</u> | | | | 23B. DATE SIGNED <u>3-8-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Eugene Owens M.D.</u> | | | | 23D. ADDRESS <u>1735 E Federal St</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-9-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>3/11/71</u> | | 25B. NAME OF REGISTRAR <u>Walter E. Taylor M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Morton & Dyett F. H. 1701 Laurens St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

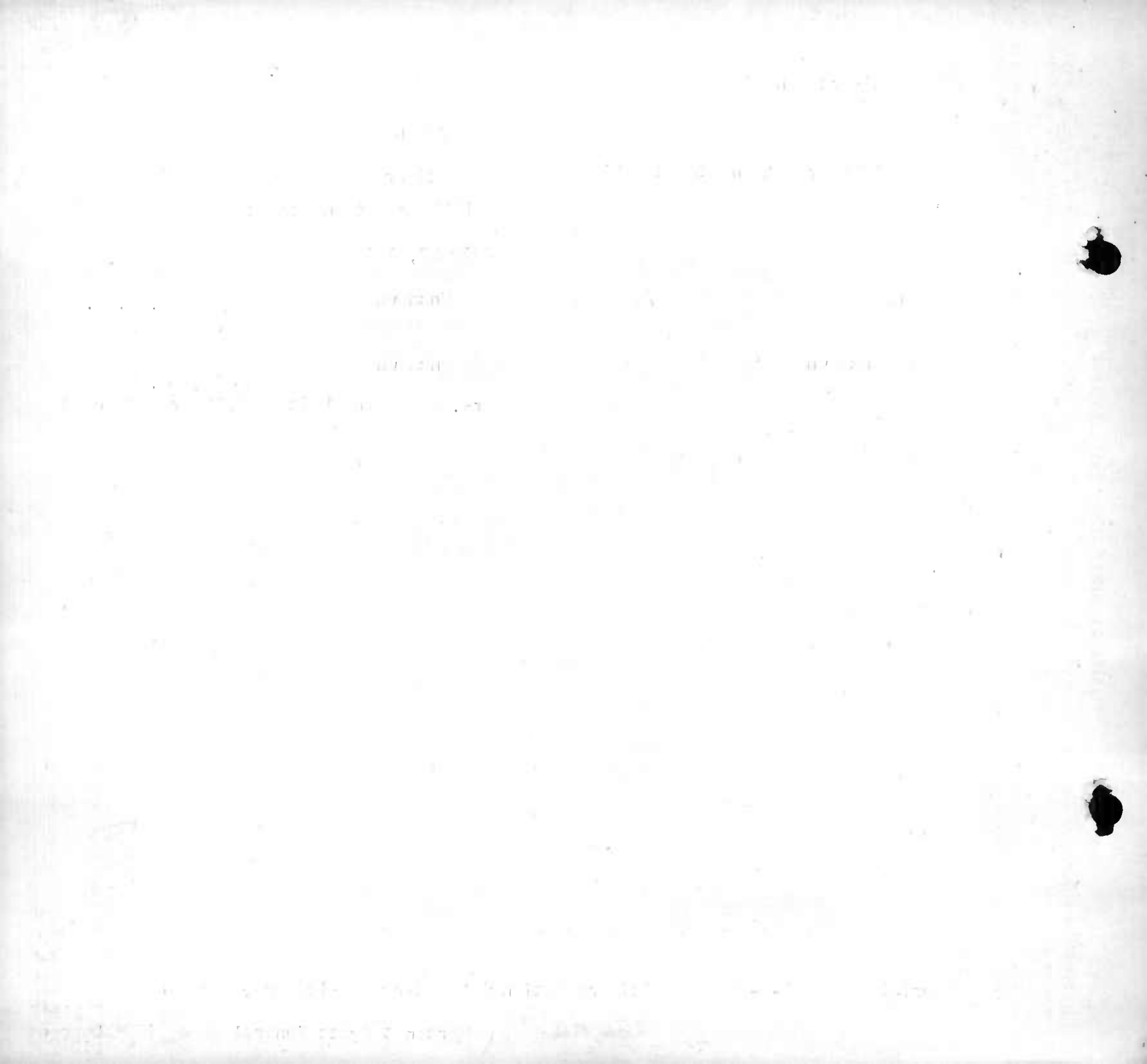
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2350 | |
|--|--|---|---|---|------------------------------------|
| BIRTH NO. 71 2350 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) GLADYS C. Bourne | | | 2. DATE AND HOUR OF DEATH 3-5-71 8:00 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 46 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 1606 | | |
| 5. SEX F | | 6. RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-8-42 |
| 9. AGE (In years last birthday) 28 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Bourne | | | 14. MOTHER'S MAIDEN NAME FLORENCE TINE Bates | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-38-8906 | | 17. INFORMANT MOTHER Joseph Bourne Baltimore | |
| 18. 427.6 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) VENTRICULAR FIBILLATION | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Thrombocytopenic Purpura; Hemolytic Anemia 1 month | | | | | |
| 19A. DATE OF OPERATION 7 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-5-71 to 3-5-71 that (I) (we) last saw the deceased alive on 3-5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Angelita A. Topacio | | | | 23B. DATE SIGNED 3-8-71 | |
| 23C. PHYSICIAN'S NAME (Type) ANGELITA A. TOPACIO | | 23D. ADDRESS LUTHERAN HOSPITAL ARMDORION ST. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY Arbutus Mem | |
| 24D. LOCATION Baltimore Md 21205 | | 24E. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | | 24F. NAME OF REGISTRAR Alfred E. Jolley, R.D. | |
| 24G. FUNERAL DIRECTOR Walter D. Dyett | | 24H. ADDRESS F.H. 1701-1705 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2351</u> | |
|---|---|---|---|---|--|
| BIRTH NO. <u>71 2351</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Albert Deneal</u> | | 2. DATE AND HOUR OF DEATH <u>3-2-71</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00 1732 Presstman Street</u> | | A. STATE <u>Maryland</u> | | B. COUNTY <u>1502</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>1732 Presstman Street</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 27, 1914</u> | 9. AGE (In years lost birthday) <u>56</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>n/a</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>N/A</u> | | 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>Unknown</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Josephine White</u> ADDRESS <u>Balo, Md. 21217</u> | | | |
| 18. <u>492 X 1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>probable acute MI or pulmonary embolus</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>essential hypertension</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>unknown</u> | | | |
| (C) <u>pulmonary emphysema</u> | | <u>unknown</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>chronic alcoholism</u> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) <u>No</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>January 28</u> 19 <u>71</u> to <u>19</u> 19 <u>71</u> , that (I) was last saw the deceased alive on <u>February 19</u> 19 <u>71</u> and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Lynne I. Neefe</u> | | 23B. DATE SIGNED <u>3-7-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Lynne I. Neefe, M.D.</u> | |
| 23D. ADDRESS <u>6008 E. Pratt St., Balto., Md.</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>3-8-71</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1971</u> | 25B. NAME OF REGISTRAR <u>John B. Taylor, M.D.</u> | 25C. FUNERAL DIRECTOR <u>Morton & Dyett Funeral Home</u> | | ADDRESS <u>1701 Laurens</u> | |



FUNERAL DIRECTOR: IMPORTANT

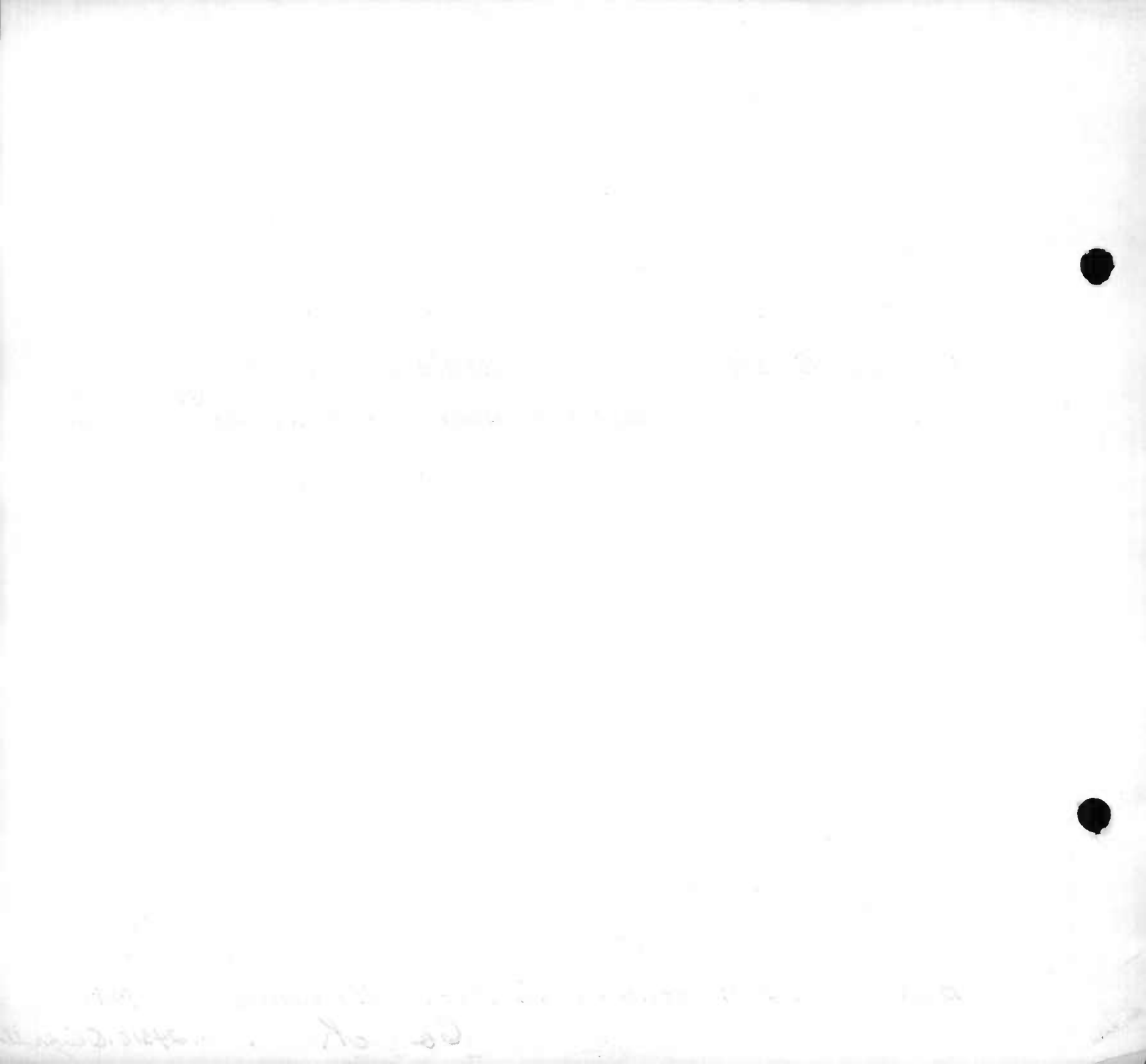
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2352</u> | |
|---|------------------|--|---|---|---|
| BIRTH NO. <u>71 2352</u> | | 1. NAME OF DECEASED (Type or Print) <u>Mayo, Estelle</u> | | 2. DATE AND HOUR OF DEATH <u>March 7, 1971 10:20 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u> <u>42 Baltimore, Maryland 21205</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | C. CITY OR TOWN <u>Baltimore</u> |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | E. STREET AND NUMBER <u>4008 Springdale Ave</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>8-2-06</u> | | 9. AGE (In years last birthday) <u>64</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Private</u> | | 11. BIRTHPLACE (State or foreign country) <u>Crew, Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Shirley Smith</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Anna Eliza</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Wilton Mayo</u> | | | |
| 18. <u>182.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardio respiratory failure</u> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Terminal Cancer</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Endometrial Carcinoma of uterus</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>None</u> | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: <u>None</u> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1971</u> to <u>March 7, 1971</u> that (I) (we) last saw the deceased alive on <u>March 7, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Antonio Ong, M.D.</u> | | 23B. DATE SIGNED <u>3-7-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>ANTONIO ONG, M.D.</u> | |
| 23D. ADDRESS <u>Sinai Hosp. of Baltimore, Md 21205</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 24B. DATE <u>3-10-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 - 1971</u> | | 25B. NAME OF REGISTRAR <u>Phyllis E. Fisher, R.D.</u> | | 25C. FUNERAL DIRECTOR <u>Rudolph J. Collick</u> | |
| 25D. ADDRESS <u>2431 E. Oliver St.</u> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| T 520 1 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2353 | |
|--|--|--|--|--|---|
| 71 2353 | | BIRTH NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>MARDE E. Thomas</u> | | | 2. DATE AND HOUR OF DEATH <u>3-1-71</u> <u>3:45</u> <u>P</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39 Provident Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1304</u> | | |
| 5. SEX <u>F</u> | | 6. RACE <u>Black</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-20-10</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (in years lost birthday) <u>60</u> | 11. BIRTHPLACE (State or foreign country) <u>U.S.A., Georgia</u> |
| 13. FATHER'S NAME <u>Cleave Small</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mollie Gearlds</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>261-B-2151</u> | | 17. INFORMANT <u>Willie T. Pittman</u> ADDRESS <u>Glen Burnie Md.</u> | |
| 18. <u>195.1</u> CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory Failure</u> | | <u>0</u> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) <u>Pleural effusion</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>1 week</u> |
| | | | (C) <u>Carcinoma, pelvic, metastatic</u> | | <u>7 months</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | <u>Cardiac failure</u> | | <u>1 hr</u> |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Edward O. Hunt, Jr.</u> DEGREE | | | 23B. DATE SIGNED <u>3/1/71</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type) <u>Edward O. Hunt, Jr.</u> DEGREE | | | 23D. ADDRESS <u>Provident Hospital</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-5-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore</u> | | 24E. STATE <u>Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9, 1971</u> | |
| 25B. NAME OF REGISTRAR <u>Robert E. Gaber, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Gallick F. H. 243/E. Oliver St.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2354 | |
|---|---------------------|---|--|--|--|
| B-616 71 2354 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | REG. NO. | | 71 2354 | |
| 1. NAME OF DECEASED (Type or Print) <u>Sarah Barber</u> | | | 2. DATE AND HOUR OF DEATH <u>3-5-71</u> <u>10:00 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY Hospital</u> <u>38</u> | | | A. STATE <u>md.</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | E. STREET AND NUMBER <u>2752 Mosher St.</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/14/71</u> | 9. AGE (in years last birthday) <u>53</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) <u>md</u> | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | | 12. CITIZEN OF WHAT COUNTRY | | |
| 13. FATHER'S NAME <u>Benny Barber</u> | | | 14. MOTHER'S MAIDEN NAME <u>Nancy Chase</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mary Curtis</u> ADDRESS <u>2742 Mosher St.</u> |
| 18. <u>3970 14 011.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>TRICUSPID INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>TUBERCULOSIS</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 weeks</u> <u>1 year</u> <u>23 years</u> |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-16-71</u> to <u>3-5-71</u> that (I) (we) last saw the deceased alive on <u>3-5-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>H.A. Brice, Jr. M.D.</u> | | | | 23B. DATE SIGNED <u>3/5/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>H.A. Brice, Jr. M.D.</u> | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-11-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Charles E. Taylor, R.D.</u> | | 25C. FUNERAL DIRECTOR <u>Charles Evans Hughes</u> ADDRESS <u>1532 Hollins St.</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

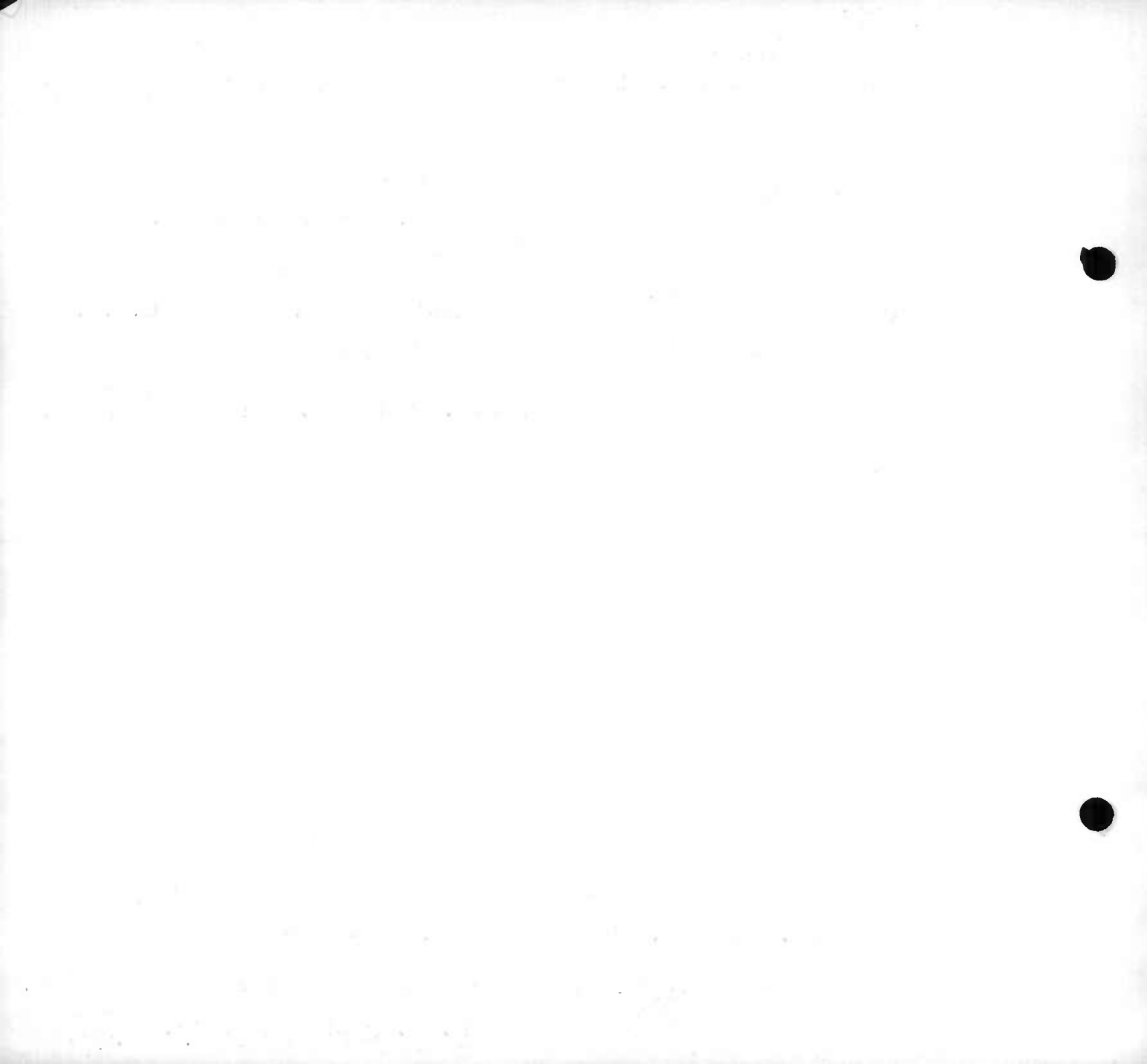
| Baltimore City Health Department | | | | 71 2355 | | 71 2355 | |
|---|-------------------------|---|--|---|--|---|---|
| 71 2355 CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| BIRTH NO. <u>H-160</u> | | | | 1. NAME OF DECEASED (Type or Print) <u>Rosalyn R. Hopper</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>3-7-71</u> | | | | M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1513</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>4052 Park Heights Ave</u> | | | | C. CITY OR TOWN <u>Balto.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>4052 Park Heights Ave</u> | | | | | | | |
| 5. SEX <u>F.</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-24-49</u> | 9. AGE (In years last birthday) <u>22</u> | 10. Under 1 Yr. Months: Days | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aide</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
| 13. FATHER'S NAME <u>Grady Pearson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Nellie Hopper</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Nellie Hopper</u> | | |
| 18. <u>1519 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>carcinomatous to lungs</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>adenocarcinoma of stomach</u> <u>20 months</u> | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>of pelvis</u> (B) <u>adenocarcinoma of stomach</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 months</u> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>July 1969</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>adenocarcinoma of stomach</u> | | 20A. AUTOPSY? (Yes or No) _____ | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>July</u> 19 <u>69</u> to <u>March</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Larry L. Nobel</u> | | | | 23B. DATE SIGNED <u>3/9/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>GARY L. NOBEL</u> | |
| 23D. ADDRESS <u>Univ. Hosp. Balto Md</u> | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 24B. DATE <u>3-11-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u> | | 24D. LOCATION <u>Westport</u> | | (State) <u>Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1971</u> | | 25B. NAME OF REGISTRAR <u>John E. Kelly</u> | | 25C. FUNERAL DIRECTOR <u>E. L. Hight</u> | | ADDRESS <u>Funeral Home 1129 N. Carolina</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2356 | |
| D-353 71 2356 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Judge Anthony F. DiDomenico | | 2. DATE AND HOUR OF DEATH March 6, 1971 11:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 703 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 805 N. Patterson Park Ave. | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-24-1905 9. AGE (In years last birthday) 65 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Judge | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. City Orphans Court | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Salvatore DiDomenico | | 14. MOTHER'S MAIDEN NAME Tomasina LaManna | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-36-8433 | |
| 17. INFORMANT Mrs. Philippa M. Pontier | | 20810 Laurel, Md. | |
| 18. 25-0.9-188X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic heart disease Bladder diabetes mellitus, C.A. cerebrovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 2/2 19 67 to 3/6 19 71 that (1) (we) last saw the deceased alive on 2/12 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Charles I. Siegel MD | | 23B. DATE SIGNED 3/8/71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Charles I. Siegel | | 23D. ADDRESS 11 E. Chase Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3-11-1971 | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1971 | 25B. NAME OF REGISTRAR Robert E. [Signature] | 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4005 York Road Balto., Md. 21212 | |



M-460 71 2357

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 2357

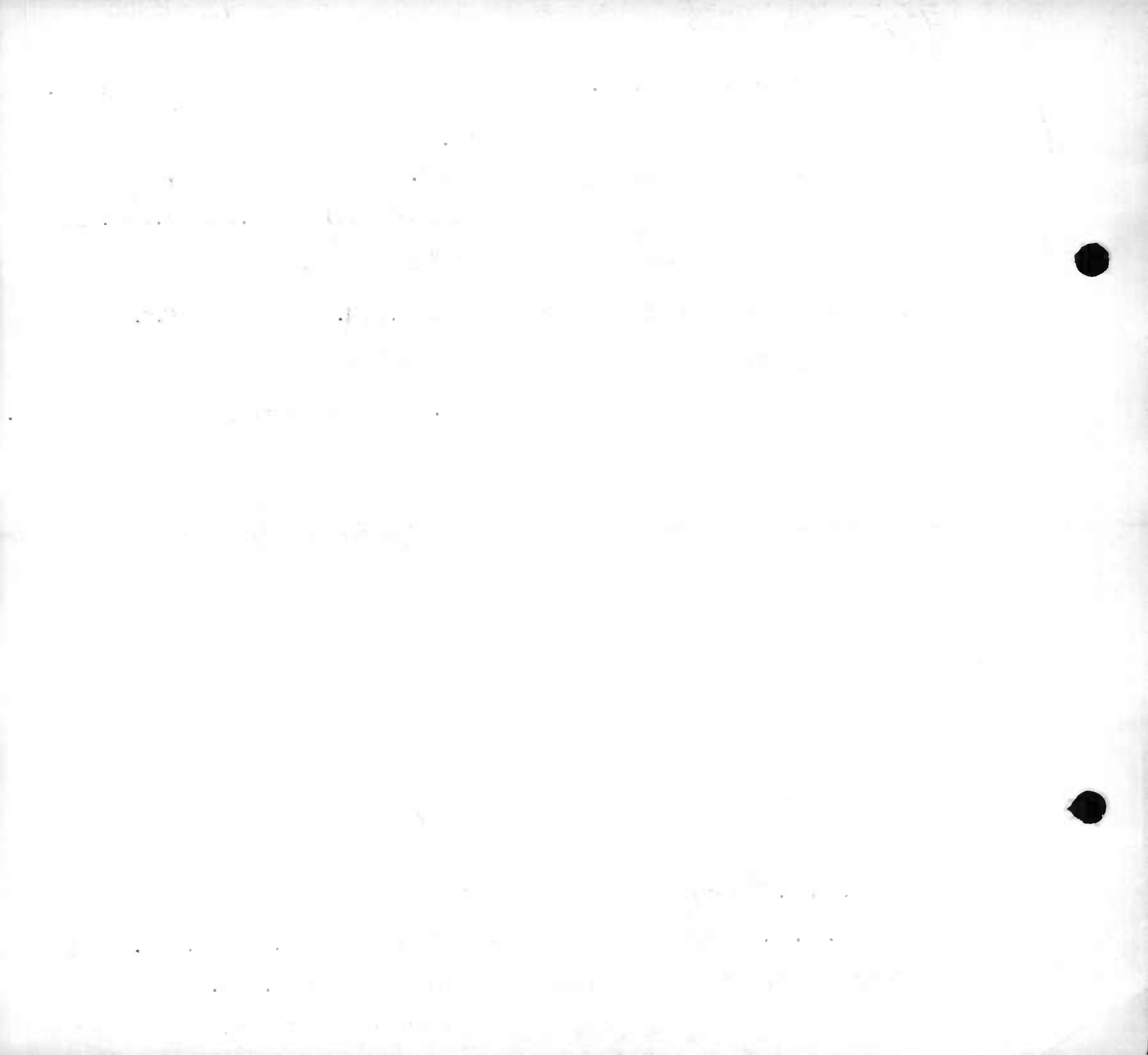
BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Tommy Miller | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 2 Day 28 Year 71 Hour 1:17 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital | | 3. DATE PRONOUNCED DEAD Month 2 Day 28 Year 71 Hour 1:17 p.m. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 6-19-56 | | 10. AGE (In years last birthday) 14 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School | | 15. MOTHER'S MAIDEN NAME Gerturde R | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Albert Miller | | ADDRESS 338 Penrose Ave | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stabwound of chest ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET 2200 blk. Carey Street | |
| 22D. TIME OF INJURY (APPROX.) 2 28 71 1:00 p.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? Subject was stabbed during altercation. | | 21. AUTOPSY? (Yes or No) yes | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. | | DATE SIGNED 3/1/74 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem & Co | | 24D. LOCATION (City, town, or county) (State) Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9, 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Rayner Sanders | | ADDRESS 217 E. Preston St | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2358 | | REG. NO. | |
|--|--------------|---|--|---|---------------------------------------|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) John August Ackermann, Jr. | | 2. DATE AND HOUR OF DEATH 3/3/71 11:30 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2633 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltl. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3207 Chesterfield Ave., Balto., Md. 21213 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10/30/02 | 9. AGE (In years last birthday) 68 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Smelkinson & Son | | 11. BIRTHPLACE (State or foreign country) Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME John Ackermann | | | | 14. MOTHER'S MAIDEN NAME Matilda | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Elsie Ackermann, 3207 Chesterfield Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis (B) INTERMEDIATE CARDIO-VASCULAR DISEASE (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/17 1958 to 3/3 1971 that (I) (we) last saw the deceased alive on 1/6 1977 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. L. B. Stevens | | | | 23B. DATE SIGNED 3/4/71 | | 23C. PHYSICIAN'S NAME (Type) Dr. L. B. Stevens | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | | | 24B. DATE 3/8/71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION Balto., Md. | | | | 24E. ADDRESS 3400 Erdman Ave., Balto., Md. 21213 | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR Schimpek Funeral Home | | 25D. ADDRESS 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

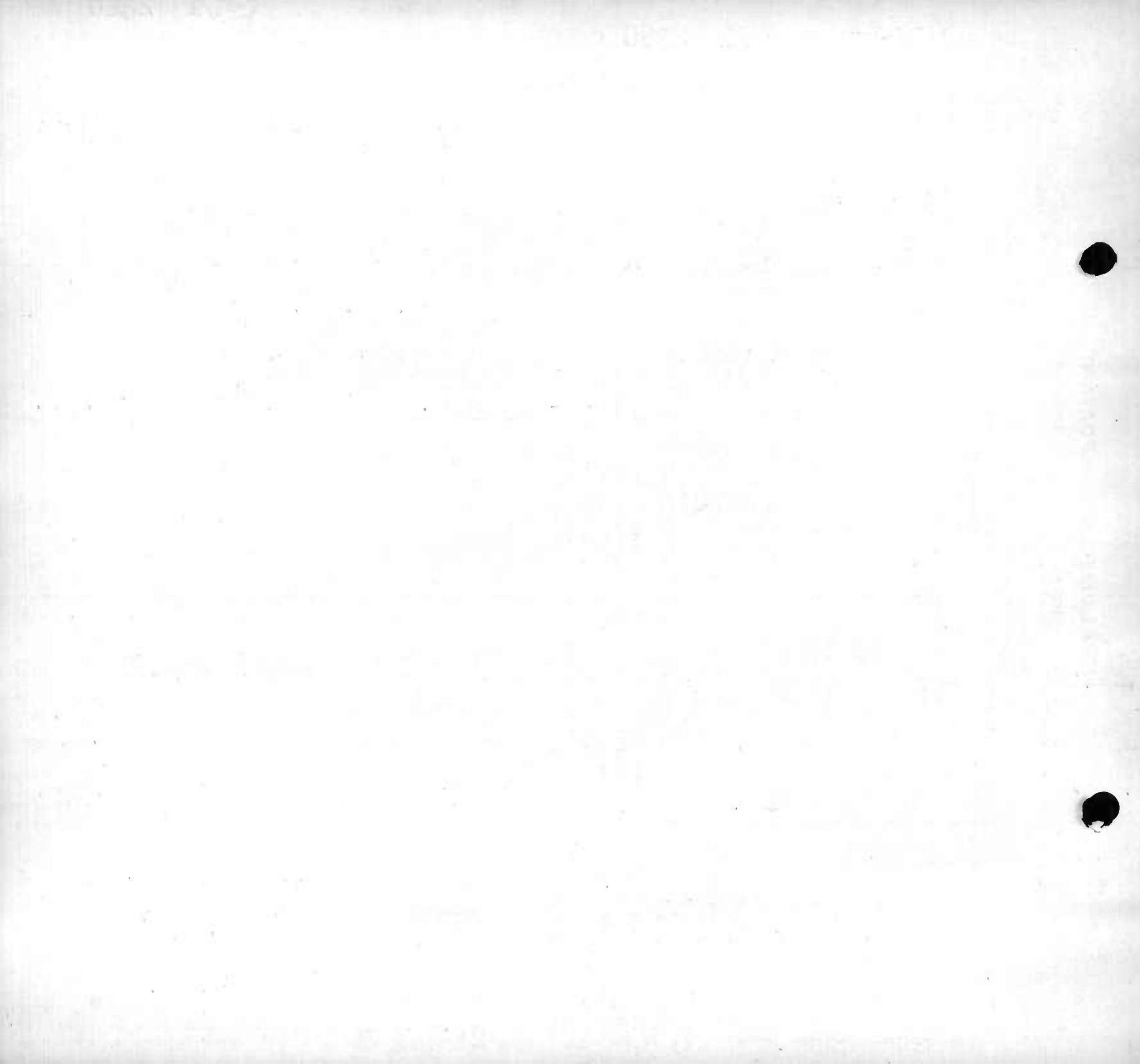
| | | | | | |
|--|--------------|---|-----------------------------|--|---|
| 7-622 71 2359 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2359 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Charles Evan Frisius | | Mar. 5, 1971 3: 50 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Md. | | B. COUNTY 2733 | |
| US Public Health Service Hospital 2X 3100 Wyman Parkway | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 4913 Morello Rd. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/22/10 | 9. AGE (in years last birthday) 60 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Capt. | | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer | | 11. BIRTHPLACE (State or foreign country) Calif. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Fred A. Frisius | | 14. MOTHER'S MAIDEN NAME Pauline Grant | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 676-16-9577 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days 6 mos. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | Metastatic squamous cell carcinoma of the esophagus | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Apr. 24</u> 19 <u>71</u> to <u>Mar. 5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Mar. 5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Roger Little, MD | | 23B. DATE SIGNED 3/5/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) R. Roger Little, Surgeon (R) | | 23D. ADDRESS US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) cremation | | 24B. DATE 3/8/71 | | 24C. NAME of CEMETERY or CREMATORY Greenmount Crematory | |
| 24D. LOCATION Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. [unclear] | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Home, 3331 Brehms Lane | | 25D. ADDRESS Balto., Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2360</u> |
|--|-------------------------|---|--|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>KNETZER, CATHERINE E.</u> | | 2. DATE AND HOUR OF DEATH <u>3/7/71</u> <u>1:15</u> <u>4</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MONTEBELLO STATE HOSPITAL</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE CO.</u> C. CITY OR TOWN <u>DWINGS MILL</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>GIN RITTERS LANE</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/3/96</u> | 9. AGE (In years last birthday) <u>74</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>William W. Frank</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Florence V. Ginneman</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>218-05-0477</u> | | 17. INFORMANT <u>Miss. Margaret A. Frank</u> ADDRESS <u>Balto. Md.</u> | | |
| CAUSE OF DEATH | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteimia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 19. IMMEDIATE CAUSE <u>METASTATIC CARCINOMA OF BREAST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 years</u> | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (A) | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | (If in Baltimore City, give exact location) | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (this hospital) attended the deceased from <u>12/15</u> 19 <u>70</u> to <u>3/7</u> 19 <u>71</u>, that (we) last saw the deceased alive on <u>3/7/71</u> 19 <u>71</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Joseph Kenneth Marshall, Jr., M.D.</u> | | 23B. DATE SIGNED <u>3/7/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>JOSEPH KENNETH MARSHALL, JR.</u> |
| 23D. ADDRESS <u>MONTEBELLO STATE HOSPITAL</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | |
| 24B. DATE <u>March 9, 1971</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1971</u> | | 25B. NAME OF REGISTRAR <u>J. F. Eline</u> | | 25C. FUNERAL DIRECTOR <u>J. F. Eline & Sons</u> ADDRESS <u>Reisterstown, Md.</u> |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 71 2361 | | | | | | | | | |
| BIRTH NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) THOMAS C. HOWARD | | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 6, 1971 2:50 A.M. | | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL | | | | | 3. DATE PRONOUNCED DEAD Month Day Year March 6, 1971 2:50 A.M. | | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel | | | | | C. CITY OR TOWN Jessup D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 6. SEX Male | | 7. RACE White | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER 7482 Montevideo Ct. | | | |
| 9. DATE OF BIRTH March 18, 1953 | | 10. AGE (In years last birthday) 17 | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Melvin P. Howard, Sr. | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 15. MOTHER'S MAIDEN NAME Mary A. Rider | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 17. SOCIAL SECURITY NO. 216 60 7062 | | 18. INFORMANT Mr. Melvin P. Howard, Sr. (father) | | 19. ADDRESS Same As #5 | | 20. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Gunshot wound of head (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 21. AUTOPSY? (Yes or No) no | | 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 7482 Montevideo Ct. | | | |
| 22D. TIME OF INJURY (APPROX.) 3-6-71 | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Shot self | | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE March 10/71 | | 24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Pk. | | 24D. LOCATION (City, town, or county) (State) Elkridge, RFD, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Charles S. Springate, M.D. | | 25C. FUNERAL DIRECTOR R.V. Singleton | | 25D. ADDRESS Singleton Funeral Home, Glen Burnie, Md. | | | |

R. V. Smith

THE BODY OF **WALLACE** HAS BEEN RELEASED AS NON MED BY DR SPRINGATE
FUNERAL DIRECTOR: IMPORTANT

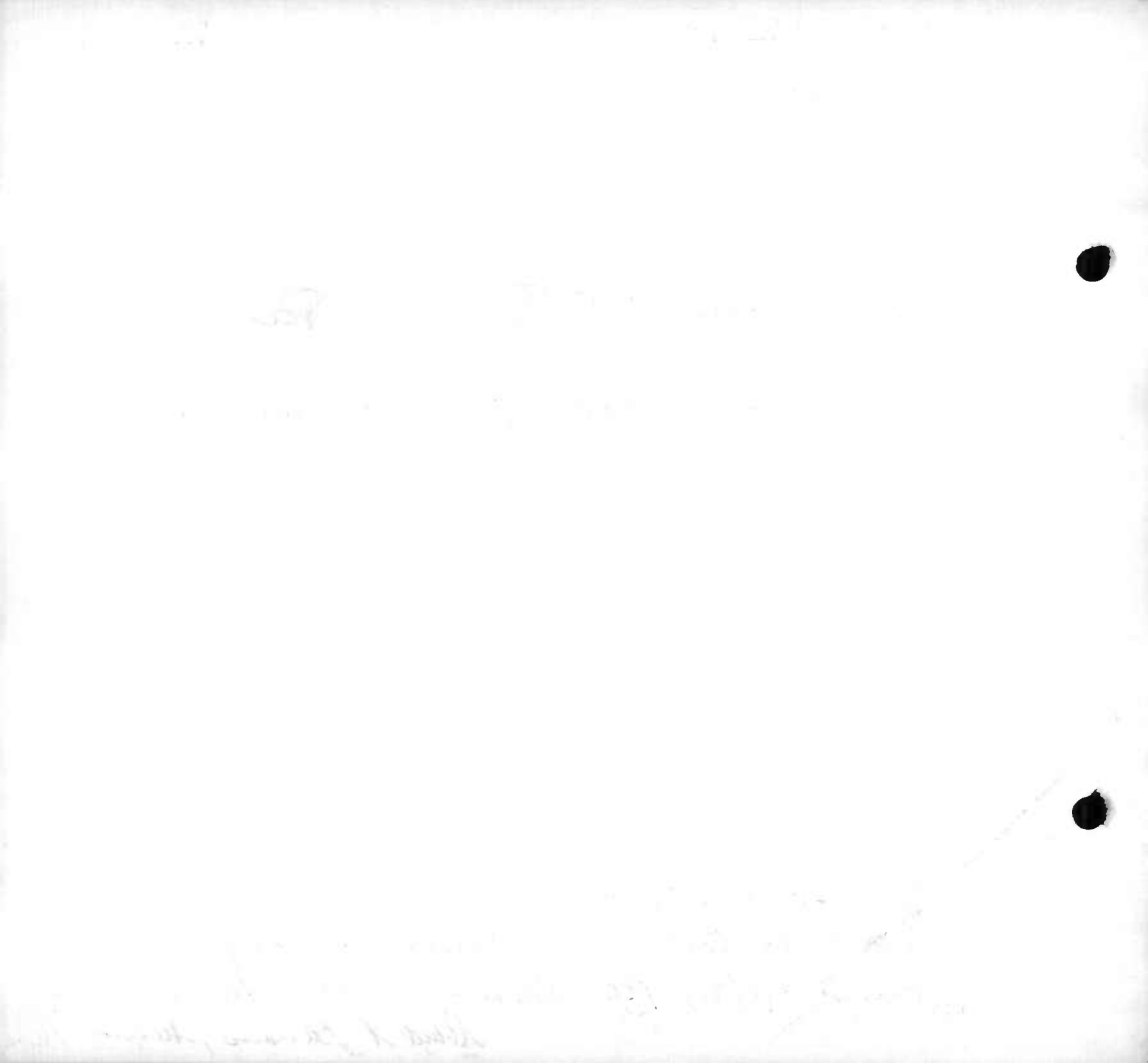
This certificate must be approved by the medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|---------|--|--|--|--------------------|--|
| W-420 71 2362 | | 71 2362 | | MENT | | X REG. NO. 71 2362 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) WALLACE, NERBERT G | | | |
| 2. DATE AND HOUR OF DEATH 3/6/71 12⁵⁰ P M. | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY WICOMICO | | | |
| CITY OR TOWN BALTIMORE | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 215 GLEN AVE | | | | 5. SEX MALE 6. RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 06/14/13 | | | | 9. AGE (in years last birthday) 57 | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REPRESENTATIVE | | | | 11. BIRTHPLACE (State or foreign country) Kentucky | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME William WALLACE | | | |
| 14. MOTHER'S MAIDEN NAME ZOOLA Howerton | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII | | | |
| 16. SOCIAL SECURITY NO. 402-18-3322 | | | | 17. INFORMANT Mrs. Lucy A. Wallace, See | | | |
| 18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE PULMONARY EMBOLUS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD - Acute Myocardial Infarction | | | | | | | |
| 19A. DATE OF OPERATION 13/6/71 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary Embolism | | | |
| 20A. AUTOPSY? (Yes or No) Yes | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. HOW DID INJURY OCCUR? | | | |
| 21F. HOW DID INJURY OCCUR? While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John M. Kellum, Jr. | | | | 23B. DATE SIGNED 3/6/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) John M. Kellum, Jr. | | | | 23D. ADDRESS Wicomico Memorial Park Salisbury Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 3/9/71 | | | |
| 24C. NAME of CEMETERY or CREMATORY Wicomico Memorial Park | | | | 24D. LOCATION (City, town, or county) (State) Salisbury Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | | | 25B. NAME OF REGISTRAR John M. Kellum, Jr. | | | |
| 25C. FUNERAL DIRECTOR John M. Kellum, Jr. | | | | 25D. ADDRESS Salisbury Maryland | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|--|---|--|--|--|--|
| 71 2363 | | | | | 71 2363 | | | | |
| BIRTH NO. | | | | | REG. NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES E. FAULKNER JR. | | | | | 2. DATE AND HOUR OF DEATH 3/3/71 12:30 P.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY ANNE ARUNDEL | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY | | | | | C. CITY OR TOWN ANNAPOLIS D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | E. STREET AND NUMBER 1087 SEAWAY DRIVE | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-29-13 | 9. AGE (in years last birthday) 57 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Police | | | | 10B. KIND OF BUSINESS OR INDUSTRY Baltimore | | 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ? | | | | 14. MOTHER'S MAIDEN NAME ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 578 096937 | | 17. INFORMANT SON - Charles Faulkner Jr. - Anne | | | |
| 18. 7960 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY ARREST | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) _____ | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-28 19 71 to 3-3 19 71 that (I) (we) last saw the deceased alive on 3-3 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE David M. Cook | | | | 23B. DATE SIGNED 3/3/71 | | 23C. PHYSICIAN'S NAME (Type) DAVID M. COOK | | | |
| 23D. ADDRESS UNIVERSITY HOSP | | | | 23E. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 3/6/71 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven | | 24D. LOCATION Glen Burnie Md | |
| 25A. NAME OF REGISTRAR Charles E. Faulkner Jr. | | | | 25B. NAME OF REGISTRAR Charles E. Faulkner Jr. | | 25C. FUNERAL DIRECTOR Robert J. Baranowski, Anne Arundel | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|-------------------------|--|--|
| C-632 71 2364 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 247 2364 | |
| BIRTH NO. _____ | | 2. DATE AND HOUR OF DEATH 3/5/94 P.M. | |
| 1. NAME OF DECEASED (Type or Print) Crutchfield Samuel | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD George Washington Nursing Home | | C. CITY OR TOWN BALTO. MD D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) George Washington Nursing Home | | E. STREET AND NUMBER _____ | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1905 5/5/91 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ | | 10B. KIND OF BUSINESS OR INDUSTRY _____ | |
| 11. BIRTHPLACE (State or foreign country) unknown | | 12. CITIZEN OF WHAT COUNTRY? _____ | |
| 13. FATHER'S NAME _____ | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. 9 15014234 | 17. INFORMANT Chart ADDRESS _____ |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 43371 [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] Cerebral Thrombosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH week | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis | | (B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Late Latent Lung | | 1968 | |
| 19A. DATE OF OPERATION _____ | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____ | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-26 19 70 to 3-5 19 71 that (I) (we) last saw the deceased alive on 3-5 19 71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Richard Tyson, M.D. | | 23B. DATE SIGNED 3-5-71 | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD TYSON, M.D. | | 23D. ADDRESS 936 W. NORTH. BALTO (17) MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3 8 71 | |
| 24C. NAME OF CEMETERY OR CREMATORY Robt Calvary | | 24D. LOCATION (City, town, or county) (State) Baltimore 17 | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert A. Taylor | |
| 25C. FUNERAL DIRECTOR William H. Taylor | | ADDRESS 2238 E. Baltimore Ave. Baltimore 17 | |

1985

1985



1985

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2365 | |
|---|---------------------|---|---|---|--|
| G-426 | | | | X REG. NO. | |
| BIRTH NO. Charles 71-2365 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) BABY BOY GOLDRING | | | 2. DATE AND HOUR OF DEATH March 2 1971 4:55 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY CHES C. CITY OR TOWN Newburg, Md. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5800 | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-28-71 | | 9. AGE (In years last birthday) 2 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? US | | | 13. FATHER'S NAME JOHN COLE | | |
| 14. MOTHER'S MAIDEN NAME MARY GOLDRING | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT John R. Cole Hughesville, Md. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II 19A. DATE OF OPERATION 2-28-71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PULMONARY HEMORRHAGE 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) IMMATURE LUNGS 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) PREMATURITY 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 2-28-71 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | | | | |
| MEDICAL CERTIFICATION 22. I certify that (I) (this hospital) attended the deceased from MARCH 1 19 71 to MARCH 2 19 71 that (I) (we) last saw the deceased alive on MARCH 2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kenneth Hoffman M.D. 23C. PHYSICIAN'S NAME (Type) KENNETH HOFFMAN M.D. | | | 23B. DATE SIGNED 3-2-71 23D. ADDRESS UNIVERSITY OF MARYLAND | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/4/71 | | 24C. NAME OF CEMETERY or CREMATORY Bryantown Ch. Cem. | |
| 24D. LOCATION (City, town, or county) (State) Bryantown Ches. Co. Md. | | 25A. DATE REC'D BY HEALTH/DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Taber, M.D. | |
| 25C. FUNERAL DIRECTOR ADAMS FUNERAL HOME | | 25D. ADDRESS AQUASCO Md. | | | |



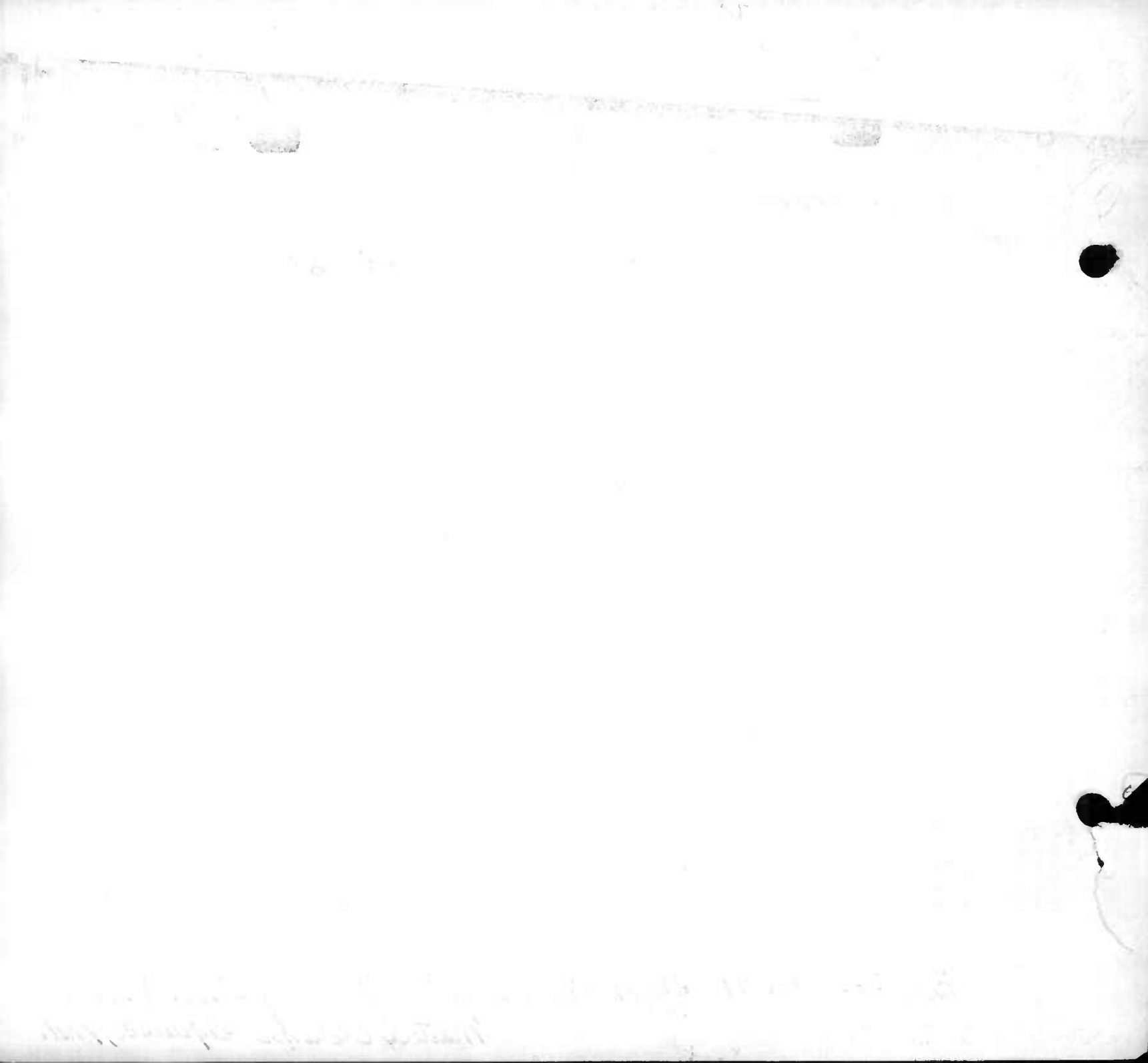
TO BE RELEASSED ON APPROVAL BY MEDICAL EXAMINER

LIP KOKKIN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|------------------------------------|---|---|
| BIRTH NO. D-520 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2366 | |
| 1. NAME OF DECEASED (Type or Print) CORNELIA DENNIS | | 2. DATE AND HOUR OF DEATH 3/2/71 4:20 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 301 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME HOSPITAL 35 100 N. BROADWAY, BALTIMORE | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 236 HERRING CT. 21231 | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/26/03 | 9. AGE (In years lost birthday) 67 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY O | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME WILLIAM DYSON | | 14. MOTHER'S MAIDEN NAME FANNIE BROWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 242 123425 | | 17. INFORMANT PATIENT | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION | | 19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ATHEROSCLEROTIC CORONARY DISEASE ? (B) DUE TO, OR AS A CONSEQUENCE OF: LEO-COLECTOMY FOR CA OF CECUM (C) DURING OPERATION | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CHIEF OF MEDICAL EXAMINER | | | | | |
| 19A. DATE OF OPERATION 3/2/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF CECUM | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) MED. NOTED | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) MD. NOTED | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/15/71 19__ to 3/2/71 19__ that (I) (we) last saw the deceased alive on 3/2/71 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ricardo M. Tuason | | | | 23B. DATE SIGNED 3/2/71 | |
| 23C. PHYSICIAN'S NAME (Type) RICARDO M. TUASON | | 23D. ADDRESS 100 N. BROADWAY BALTIMORE MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL, (Specify) Burial | | 24B. DATE 3-6-71 | | 24C. NAME of CEMETERY or CREMATORY Shiloh Com. Church Com. | |
| 24D. LOCATION Newbury-Chas. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | | |
| 25B. NAME OF REGISTRAR Robert A. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Marshall Delams Aguasco, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

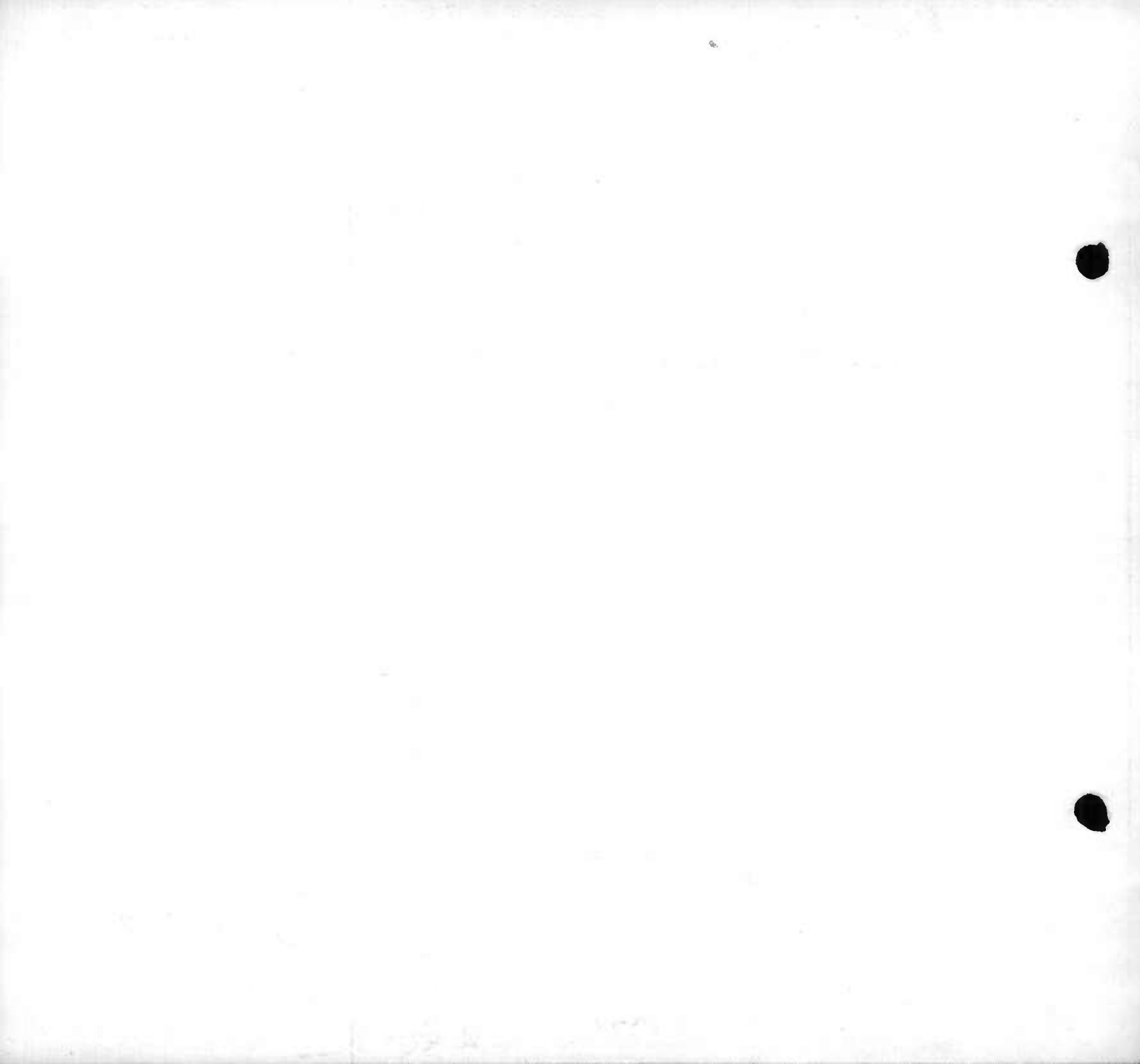
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--------------|---|--|---|---------------------------------------|---|--|
| S-536 | | 71 2367 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2367 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) SANDER, HELEN VIRGINIA | | | | 2. DATE AND HOUR OF DEATH 6TH MARCH 1971 3:50 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY OF MARYLAND HOSPITAL | | | | A. STATE MD. Talbot 7029 | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | B. COUNTY | | | |
| | | | | C. CITY OR TOWN EASTON | | | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER 709, GOLDSBORO ST. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-9-22 | 9. AGE (in years last birthday) 48 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME EDWARD PLUGGE | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH GADOW | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 224-05-9598 | | 17. INFORMANT JOHN D SANDER (HUSBAND) AS ABOVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | 19. CAUSE OF DEATH (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) CARCINOMA OF (R) TONSIL. CHRONIC ALCOHOLISM. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINS UNKNOWN 20 YRS. | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-5 19 71 to 3-6 19 71 that (I) (we) lost saw the deceased alive on 3-6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE J. H. Mather, M.D. | | | | 23B. DATE SIGNED 3-6-71 | | 23C. PHYSICIAN'S NAME (Type) JOHN H. MATHER, M.D. | |
| 23D. ADDRESS UNIVERSITY HOSPITAL | | | | 23E. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 23F. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 23G. FUNERAL DIRECTOR NEWMAN FUNERAL HOME, EASTON, MD. | | | | 23H. ADDRESS | | 23I. DATE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 3/9/1971 | | 24C. NAME OF CEMETERY OR CREMATORY SPRING HILL | |
| 24D. LOCATION EASTON, MD | | | | 24E. DATE | | 24F. NAME OF REGISTRAR | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2368</u> | |
|--|--|---|--|--|--|
| P-425 BIRTH NO. <u>71 2368</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Poulson Aubura</u> | | | 2. DATE AND HOUR OF DEATH <u>3/7/71</u> <u>2</u> <u>A</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hosp</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>907</u> | | |
| 5. SEX <u>Male</u> 6. RACE <u>Negro</u> | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 8. DATE OF BIRTH <u>10-08-06</u> | | | 9. AGE (In years last birthday) <u>64</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Lieut Paulson</u> | | | 14. MOTHER'S MAIDEN NAME <u>Alverta Young</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>224-28-6103</u> | | |
| 17. INFORMANT <u>Chart</u> | | | ADDRESS | | |
| 18. <u>59011 I</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>pyelonephritis and renal failure + stone</u> | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>—</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Inotify medical examiner <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-5</u> 19 <u>71</u> to <u>3/7</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>3/7</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>I. Chalk</u> | | | | 23B. DATE SIGNED <u>1. Chalk</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ISSAM E. CHECKH</u> | | | | 23D. ADDRESS <u>Union Memorial Hospital 317/71</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-13-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Gaskins Chapel</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Onancock, Virginia</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Sabin</u> | | 25C. FUNERAL DIRECTOR <u>Samuel J. Samuel New Church, Va</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 71 2369 | |
|---|----------------------|---|---------------------------------|---|---|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>William Roberts</u> | | | | 2. DATE AND HOUR OF DEATH <u>3/1/71</u> <u>6²⁵</u> <u>A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home + Hosp.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Lutherville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>212 Horns Ave</u> | | | |
| 5. SEX <u>male</u> | 6. RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/30/01</u> | | 9. AGE (in years last birthday) <u>69</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clergyman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William J. Roberts</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rosevelt Christian</u> | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>219 36 1542</u> | | 17. INFORMANT <u>pat.'s hosp. chart</u> | | ADDRESS | |
| 18. <u>4/12/31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>arteriosclerosis</u> | | | | (A) IMMEDIATE CAUSE <u>ASHT</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW OLD INJURY OCCURRED | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> 19 <u>71</u> to <u>3/1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/1/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Dietrich van Telchman MD</u> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>3/1/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dietrich v. Feldman MD</u> | | | | 23D. ADDRESS <u>Church Home + Hosp.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>3-3-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>St. James Ep. Church</u> | | 24D. LOCATION (City, town, or county) (State) <u>Monkton Balto. Co. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1971</u> | | 25B. NAME OF REGISTRAR <u>Reese J. J. MD</u> | | 25C. FUNERAL DIRECTOR <u>John Brundson</u> | | ADDRESS <u>610-12 York Rd</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

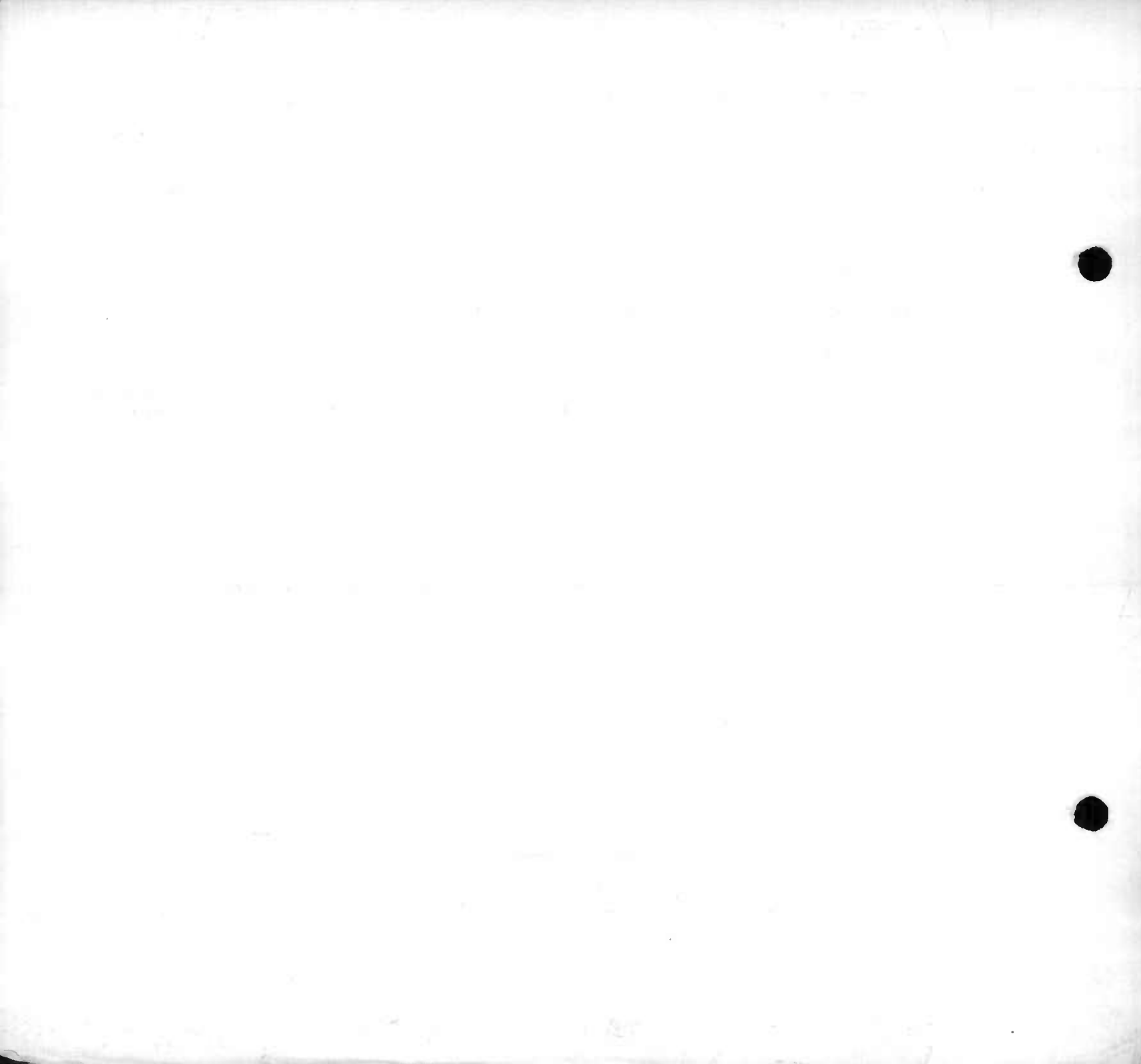
| L-530 71 2370 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2370 | |
|--|-------------------------|---|------------------------------------|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) REGINA M. LIND | | 2. DATE AND HOUR OF DEATH MARCH 5 / 71 1:35 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE BALTIMORE, MARYLAND 2748 B. COUNTY | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL 35 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 1119 E. Belvidere Ave. | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/25/13 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BOOKKEEPER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD | |
| 13. FATHER'S NAME LOUIS LIND | | 14. MOTHER'S MAIDEN NAME AGNES BUTZ | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216 01 3775 | | 17. INFORMANT MRS. MARIE QUINN | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PULMONARY MALIGNANCY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Lung Disease, i | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Lung Disease, i (B) DUE TO, OR AS A CONSEQUENCE OF: PLEURAL EFFUSION (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH indefinite | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) <u>this hospital</u> attended the deceased from <u>January 16</u> 19 <u>71</u> to <u>March 5</u> 19 <u>71</u> that (1) <u>we</u> last saw the deceased alive on <u>March 5</u> 19 <u>71</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>We</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rolando A. Mendoza | | 23B. DATE SIGNED 3/5/71 | | 23C. PHYSICIAN'S NAME (Print) ROLANDO A. MENDOZA MD. | |
| 23D. ADDRESS 100 N. Broadway, Balto., MD. (31) | | 23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 23F. DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-9-1971 | | 24C. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | |
| 24D. LOCATION (City, town, or county) (State) BALTO. Co., Md. | | 24E. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 24F. NAME OF REGISTRAR Robert E. Pabey, Md. | |
| 24G. NAME OF REGISTRAR | | 24H. FUNERAL DIRECTOR J. Walter Conklin | | 24I. ADDRESS 5444 BELAIR RD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

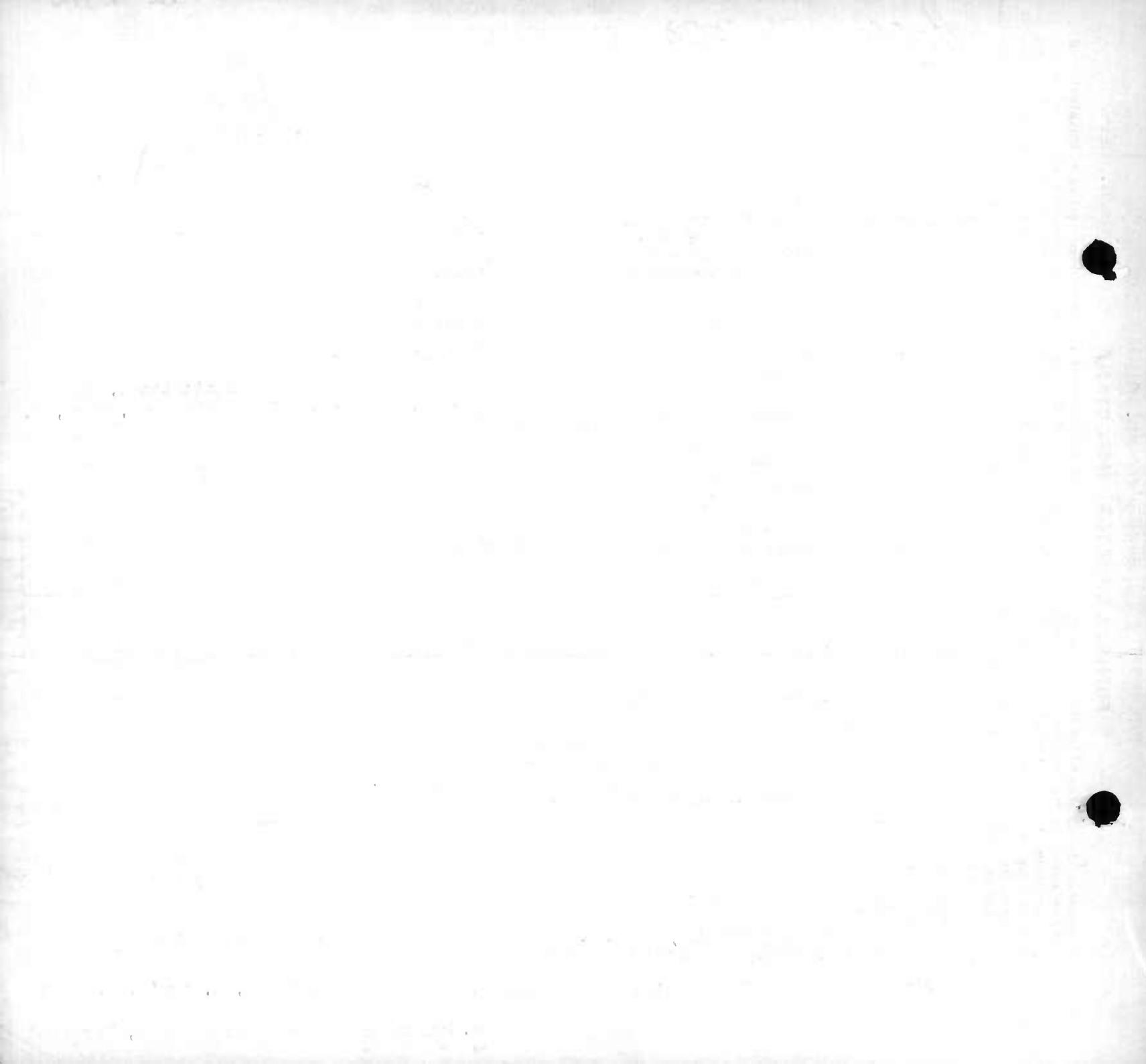
| L-350 71 2371 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2371 | |
|---|---------------------|---|--|---|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Lillian May Lydon</u> | | 2. DATE AND HOUR OF DEATH <u>3-5-71</u> <u>8:30 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2744</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Gould Convalesarium</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>3516 Mary Ave</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>08-18-88</u> | 9. AGE (in years last birthday) <u>82</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>059-14-4244</u> | | 17. INFORMANT <u>John Lydon - 3516 Mary Ave.</u> | |
| 18. <u>3099 I</u> CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.</u> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac failure</u> | | <u>Sudden</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Anteroseptal Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>4 months</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) <u>Acute & Chronic brain Syndrome</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.] | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Nov 29</u> 19 <u>70</u> to <u>March 5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>March 3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Lillian Lydon</u> | | 23B. DATE SIGNED <u>March 5-1971</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Coral Gordon MD</u> | | 23D. ADDRESS <u>64 Park Ave Baltimore MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/8/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | |
| | | 24D. LOCATION <u>Baltimore</u> | | (City, town, or county) (State) <u>Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert C. Altenburg</u> | | 25C. FUNERAL DIRECTOR <u>Robert C. Altenburg Funeral Home, Inc.</u> | |
| | | | | ADDRESS <u>3009 Harford Rd. - Balto., Md. 21214</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | CERTIFICATE OF DEATH | | REG. NO. | |
|---|--|--|--|--|--|--|--|
| H-536 71 2372 | | BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) HENDERSON, ANNIE | | 2. DATE AND HOUR OF DEATH 3-4-71 3:37 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD The Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY St. Marys | | C. CITY OR TOWN Lexington Park D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital | | | | E. STREET AND NUMBER 7 Lincolen Avenue | | F. AGE (In years last birthday) 64 | |
| 5. SEX Female | | 6. RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/26/06 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME James Courtney | | | | 14. MOTHER'S MAIDEN NAME Alice Dorsey | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Lorcy R. Henderson ADDRESS Lexington Park, Md. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/3 19 71 to 3/3 19 71 that (I) (we) last saw the deceased alive on 3/3 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Harvey Klein M.D. DEGREE | | | | 23B. DATE SIGNED 3/4/71 | | 23C. PHYSICIAN'S NAME (Type) Harvey Klein, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/71 | | 24C. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery | | 24D. LOCATION (City, town, or county) (State) Hermansville, St. Mary's, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR W. Clarke Mattingley | | 25C. FUNERAL DIRECTOR ADDRESS Leonardtwn, Maryland | | | |



| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|--|---|--|---|--|
| S-562 | | 71 2373 | | 71 2373 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| Virginia Boyd Somers | | March 5, 1971 6:20 A. | | Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 5. SEX | | 6. RACE | |
| Maryland St. Mary's 6800 | | Female | | White | |
| 7. CITY OR TOWN | | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | |
| Ridge | | 4-10-04 | | 66 | |
| 10. STREET AND NUMBER | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | Illinois | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| Elmer Slocum | | Mamie Boyd | | 327-07-7155A | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH | |
| 327-07-7155A | | BCH: Records Baltimore, Maryland 21224 | | 90% Thermal Burn | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) 90% Thermal Burn | | 40 hours | |
| 21. ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 23. Anteroseptic Heart Disease | | | |
| 24. DATE OF OPERATION | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 26. AUTOPSY (Yes or No) | |
| 3/3/71 | | Thermal Burn | | Yes | |
| 27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| Yes | | Home | | St. Mary's County, Md. | |
| 30. TIME OF INJURY (APPROX.) | | 31. INJURY OCCURRED | | 32. HOW DID INJURY OCCUR? | |
| 3/3/71 1-2:00 pm | | While At Work | | Clothes ignited while Smoking | |
| 33. I certify that (1) (this hospital) attended the deceased from 3/3 to 3/5 1971 and that (1) (we) last saw the deceased alive on 3/5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | 34. SIGNATURE | | 35. DATE SIGNED | |
| Robert E. Fabrici | | 3/5/71 | | 3/5/71 | |
| 36. PHYSICIAN'S NAME (Type) | | 37. ADDRESS | | 38. DATE | |
| Robert E. Fabrici | | 4940 Eastern Avenue Baltimore, Maryland 21224 | | Mar. 7, 1971 | |
| 39. BURIAL CREMATION, REMOVAL (Specify) | | 40. NAME of CEMETERY or CREMATORY | | 41. LOCATION (City, town, or county) (State) | |
| Burial | | Friendship Cemetery | | Ridge, St. Mary's, Maryland | |
| 42. DATE REC'D BY HEALTH DEPT. | | 43. NAME OF REGISTRAR | | 44. FUNERAL DIRECTOR | |
| MAR 10 1971 | | W. Clarke Mattingley | | Leonardtwn, Maryland | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

My dear friend

I have just received your letter

and

am very glad to hear

from you

Yours truly

Wm. Lloyd Garrison

L-105

71 2374

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2374

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) OLLIE LIPSCOMB | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month March Day 6 Year 1971 Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street and house or apartment number and location) 523 N. Edgewood Street | | 3. DATE PRONOUNCED DEAD Month March Day 6 Year 1971 Hour 7:15 P. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH Aug. 15-1914 | | 10. AGE (In years last birthday) 56 | |
| 11. BIRTHPLACE (State or foreign country) GAFFNEY S.C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 14B. KIND OF BUSINESS OR INDUSTRY CONTRACTOR | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. 212-03-1508 | |
| 18. INFORMANT MINNIE DORR | | 19. ADDRESS 198-16-715 71st St ALBANY N.Y. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of trunk (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | |
| 22D. TIME OF INJURY (APPROX.) Month 3 Day 6 Year 71 | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 523 N. Edgewood Street | | 22F. HOW DID INJURY OCCUR? -2-- Apparently dropped gun causing discharge | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED March 7, 1971 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/71 | |
| 24C. NAME OF CEMETERY or CREMATORY MT AUBURN | | 24D. LOCATION (City, town, or county) (State) Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Thurman D. Hays | | ADDRESS 638 N. Glenview St | |

Letter from M.E.'s office 8-2-71 M.H.

B-358

71 2375 BALTIMORE CITY HEALTH DEPARTMENT

71 2375

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) ALBERT BIDEN | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 99 CERTIFICATE AMENDED 3-12-71 SOUTH BALTO. GENERAL HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 8, 1971 8:44 P.M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 8/26/41 | | 10. AGE (In years lost birthday) 34 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert Biden | | 14. MOTHER'S MAIDEN NAME Anna E. Gersey | |
| 15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2505 | | E. STREET AND NUMBER 4827 Pennington Avenue | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean | | 17. SOCIAL SECURITY NO. 212 341 584 | |
| 18. INFORMANT Betty Biden Above Address | | ADDRESS | |
| 19. CAUSE OF DEATH 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hemoperitoneum due to Cirrhosis, Portal | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cirrhosis, portal | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/9/71 ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-12-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Olivet | | 24D. LOCATION (City, town, or county) (State) Baltimore - Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR John E. Faber, M.D. | |
| 25C. FUNERAL DIRECTOR McCall | | ADDRESS 130 E. Fort Ave. | |

Letter from M.E.'s office

3-12-71 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2376 | |
|---|--|---|---|---|--|
| BIRTH NO. M-255 | | 71 2376 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MAMIE EVA McMAHON | | | 2. DATE AND HOUR OF DEATH 3/8/71 9:25PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL 43 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2404 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1617 Webster St. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/11/95 | 9. AGE (In years lost birthday) 75 | 10. Under 1 Yr. Months: 75 11. Under 24 Hrs. Days: 75 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 10B. KIND OF BUSINESS OR INDUSTRY None | | |
| 11. BIRTHPLACE (State or foreign country) Md. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Robert L. Wilson | | | 14. MOTHER'S MAIDEN NAME Emma A. Johnson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 213-10-9649 | | |
| 17. INFORMANT Hosp. Records | | | ADDRESS Hosp. Records | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE ACUTE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF: (B) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CARDIOVASCULAR ACCIDENT. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (X) (this hospital) attended the deceased from 2/18/71 19 to 3/8/71 19 that (I) (we) last saw the deceased alive on 3/8/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Aye Ngwe | | | 23B. DATE SIGNED 3/8/71 | | |
| 23C. PHYSICIAN'S NAME (Type) Aye Ngwe M.D. | | | 23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/12/71 | | 24C. NAME of CEMETERY or CREMATORY Holy Cross Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore - Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | | |
| 25B. NAME OF REGISTRAR John E. Gabley, R.D. | | 25C. FUNERAL DIRECTOR McGilly 130 E. Fort Ave. | | | |



CERTIFICATE OF DEATH

REG. NO.

71 2377

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Abram Bosley

2. DATE AND HOUR OF DEATH

March 7, 1971

2:07 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

2522 McComas Ave. Baltimore, Md. 21222 005

5. SEX

Male

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

3-31-81

9. AGE (In years
last birthday)

89

If Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Self-employed

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Bosley

14. MOTHER'S MAIDEN NAME

Rachel Armacost

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-03-2845

17. INFORMANT

4940 Eastern Ave. ADDRESS

BCH Records:

Baltimore, Md. 21224

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

cardio-resp arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 hr

(B) DUE TO, OR AS A CONSEQUENCE OF:

atrial fibrillation

?

(C) DUE TO, OR AS A CONSEQUENCE OF:

subdural hematoma

5 days

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

old age

19A. DATE OF OPERATION

3/3/71

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

subdural hematoma

20A. AUTOPSY (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)☒21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

home 2522 McComas Ave

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

3 3 71

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☒

21F. HOW DID INJURY OCCUR?

post op @ hip fx-pt fell down

22. I certify that (I) (this hospital) attended the deceased from

3/3

19 71 to

3/7

19 71

that (I) (we) last saw the deceased alive on

3/7

19 71 and that (I) (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W. L. McGAVRAN M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

3/7/71

23C. PHYSICIAN'S
NAME (Type)

W. L. MCGAVRAN M.D.

23D. ADDRESS

BCH 4940 Eastern Ave.
Baltimore, Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-11-71

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION
(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 10 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

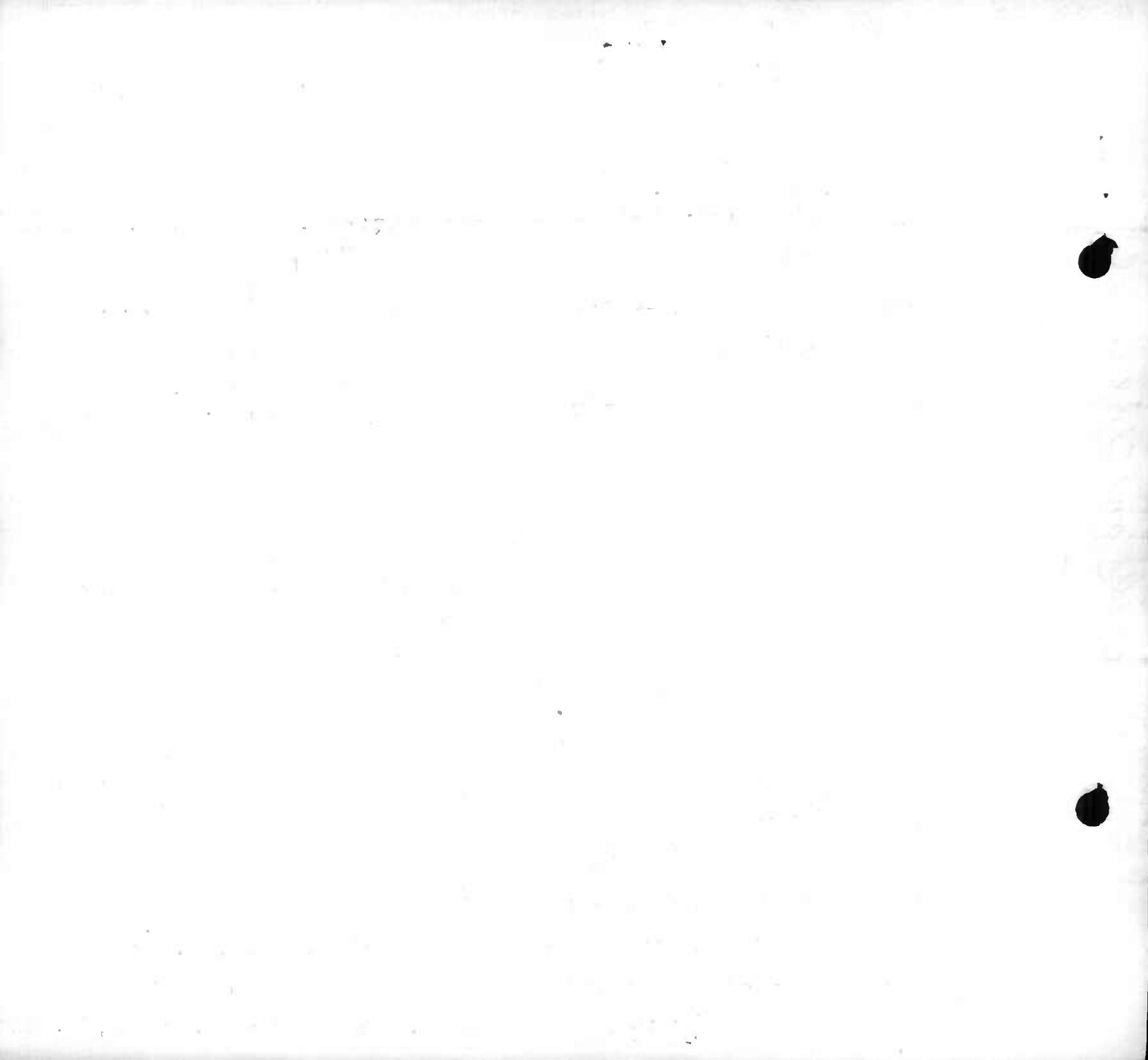
25C. FUNERAL DIRECTOR

John J. Duda 7922 Wise Ave. Dundalk, Md. 21224

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

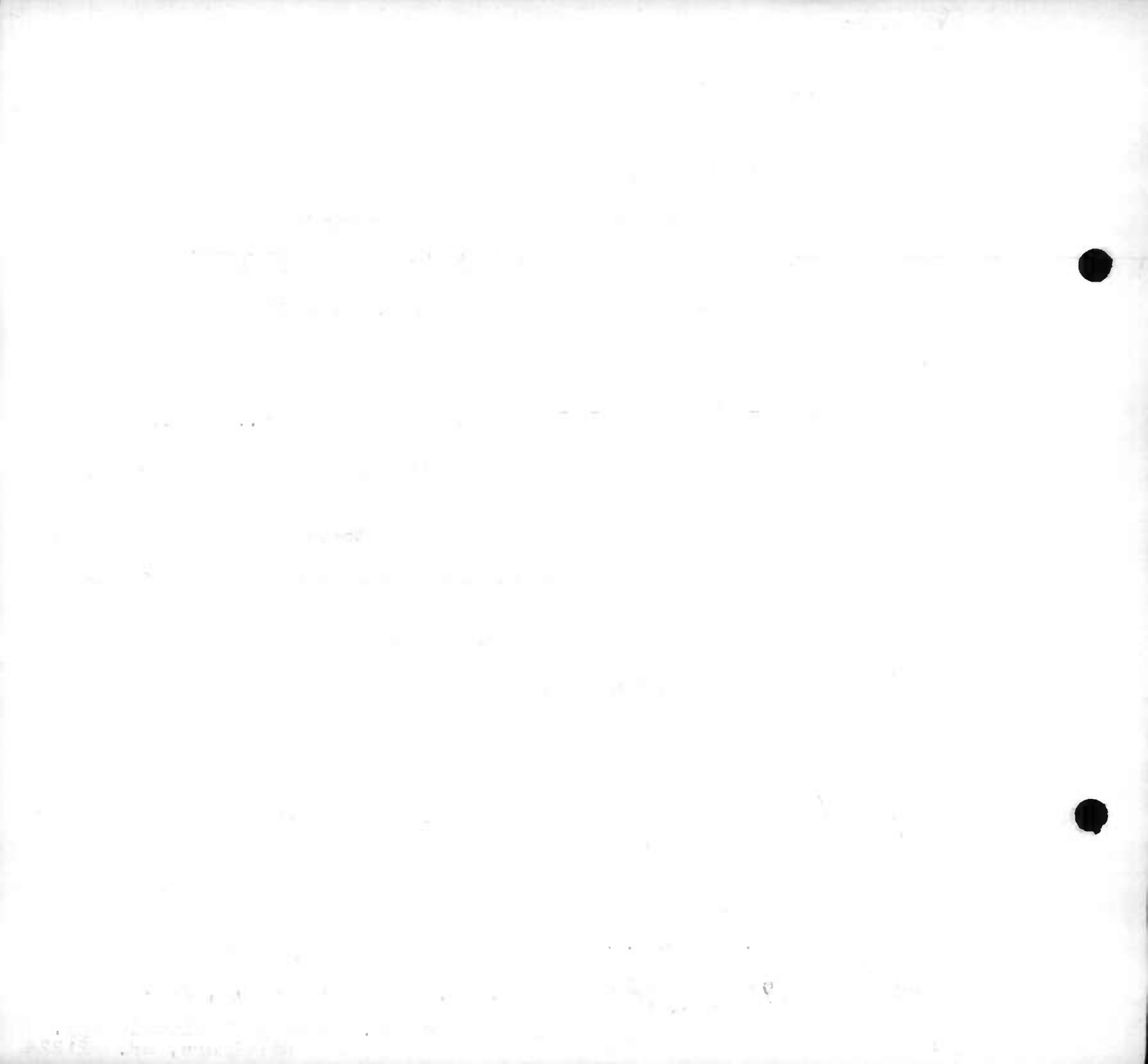
Released on Approval
FUNERAL DIRECTOR: IMPORTANT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2378</u> | |
|--|----------------------|---|---------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) DUNGAN, DONALD LLOYD | | 2. DATE AND HOUR OF DEATH 3/4/71 3:20 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2758 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1710 Swansea Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 5/20/23 | 9. AGE (In years last birthday) 47 | 10. Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Acme Stores | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Edward Dungan | | | |
| 14. MOTHER'S MAIDEN NAME Katheryn Kepper | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2/18/43 - 1/10/46 | | | |
| 16. SOCIAL SECURITY NO. 215-12-7268 | | 17. INFORMANT ADDRESS VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 431.91 + 303.9 | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Intracerebral hematoma DUE TO, OR AS A CONSEQUENCE OF: (C) Intracerebral hemorrhage | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 3 to 4 days 3 to 4 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic alcoholism | | | | | |
| 19A. DATE OF OPERATION 3/3/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED to rule out subdural hematoma | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from March 1st 19 71 to March 4th 19 71 that (H) (we) last saw the deceased alive on March 4th 19 71 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John F. Rogers | | 23B. DATE SIGNED 3/5/71 | | 23C. PHYSICIAN'S NAME (Type) JOHN F. ROGERS, M.D. | |
| 23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 3/8/71 | | 24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Park | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Hager | | 25C. FUNERAL DIRECTOR ADDRESS George J. Gonce 3001 Ritchie Hgy. Baltimore, Md. 21225 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2378 | |
|--|---|--|--|---|---|
| C-620 71 2378 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) ETTA CROOK | | 2. DATE AND HOUR OF DEATH 3/7/71- 3:50 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND, BALTO. B. COUNTY 401 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSP. REDWOOD + GREENEST. | | | C. CITY OR TOWN CITY. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 113 N. PACA. ST. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-20-01 | 9. AGE (In years last birthday) 68 69 | If Under 1 Tr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN. | | 10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN. | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? USA. |
| 13. FATHER'S NAME XXXXXXXXXXXXX A.V. McCoy | | | 14. MOTHER'S MAIDEN NAME XXXXXXXXXXXXX Ina Daniel MC COY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. UNKNOWN | 17. INFORMANT HOSPITAL RECORDS | | |
| 18. CAUSE OF DEATH 44101 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) IMMEDIATE CAUSE PROBABLE MI DUE TO, OR AS A CONSEQUENCE OF: (B) DISSECTING AORTIC ANEURYSM - DUE TO, OR AS A CONSEQUENCE OF: (C) ASHOUD |
| | | | | | 2 WKS. |
| | | | | | 10 YRS |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHRONIC BRONCHITIS | | | | | 10 YRS |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/21/71 19 71 to 3/7/71 19 71 that (I) (we) last saw the deceased alive on 2/6/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Marguerite T. Moran M.D. | | | | 23B. DATE SIGNED 3/7/71 | |
| 23C. PHYSICIAN'S NAME (Type) MARGUERITE T. MORAN. M.D. | | 23D. ADDRESS UNIVERSITY HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 3-10-71 | 24C. NAME OF CEMETERY OR CREMATORY AMITY PRESBYTERIAN CEMETERY | | 24D. LOCATION (City, town, or county) (State) CHARLOTTE, N.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Howard H. Hubbard | | 25C. FUNERAL DIRECTOR HOWARD H. HUBBARD | |
| | | | | ADDRESS 4107 WILKENS AVE. 21229 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

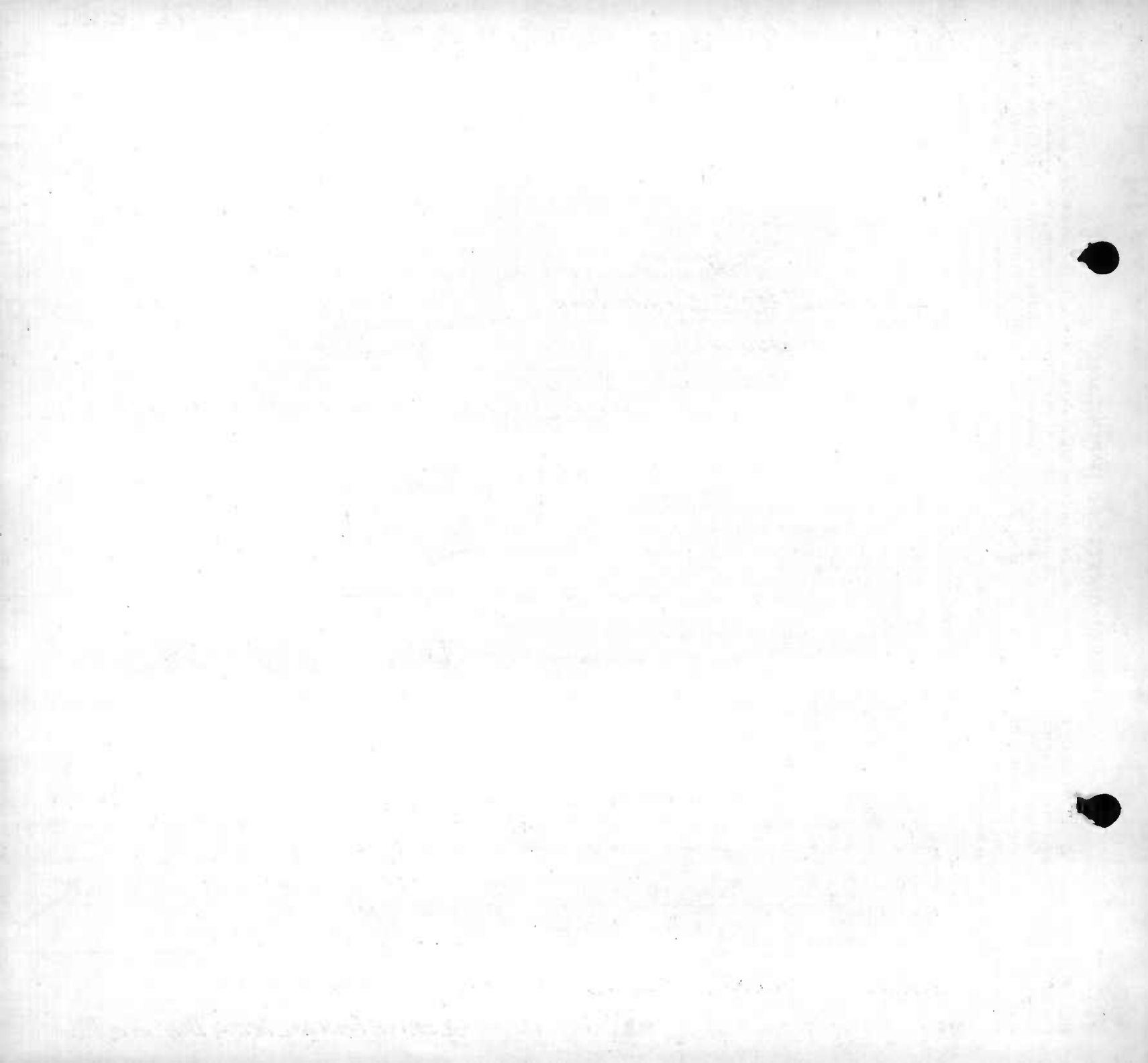
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2380 | |
|--|---|---|--|--|---|
| H-553 71 2380 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Charles A. Hammond, Jr. | | 2. DATE AND HOUR OF DEATH March 6, 1971 10:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 3011 2nd. Ave. | | 21234 | |
| 5. SEX Male | 6. RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-5-26 | 9. AGE (In years last birthday) 44 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bonded Armor Carrier Service | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | |
| 13. FATHER'S NAME Charles A. Hammond, Sr. | | 14. MOTHER'S MAIDEN NAME ? | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1946-1966 | | 16. SOCIAL SECURITY NO. 164-24-0008 | | 17. INFORMANT Hospital Records | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BACTERIAL ENDOCARDITIS, ACUTE, AORTIC VALVE | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RHEUMATIC HEART DISEASE, MILD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/6/71 to 3/6/71 19____ that (I) (we) last saw the deceased alive on 3/6/71 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Victor R. Felipa | | | | 23B. DATE SIGNED 3/7/71 | |
| 23C. PHYSICIAN'S NAME (Type) Victor R. FELIPA | | | | 23D. ADDRESS Maryland General Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/71 | | 24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley | |
| 24D. LOCATION (City, town, or county) BALTO MD | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Chas. St. Evans | |
| 25C. FUNERAL DIRECTOR 8802 Hartford Rd | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

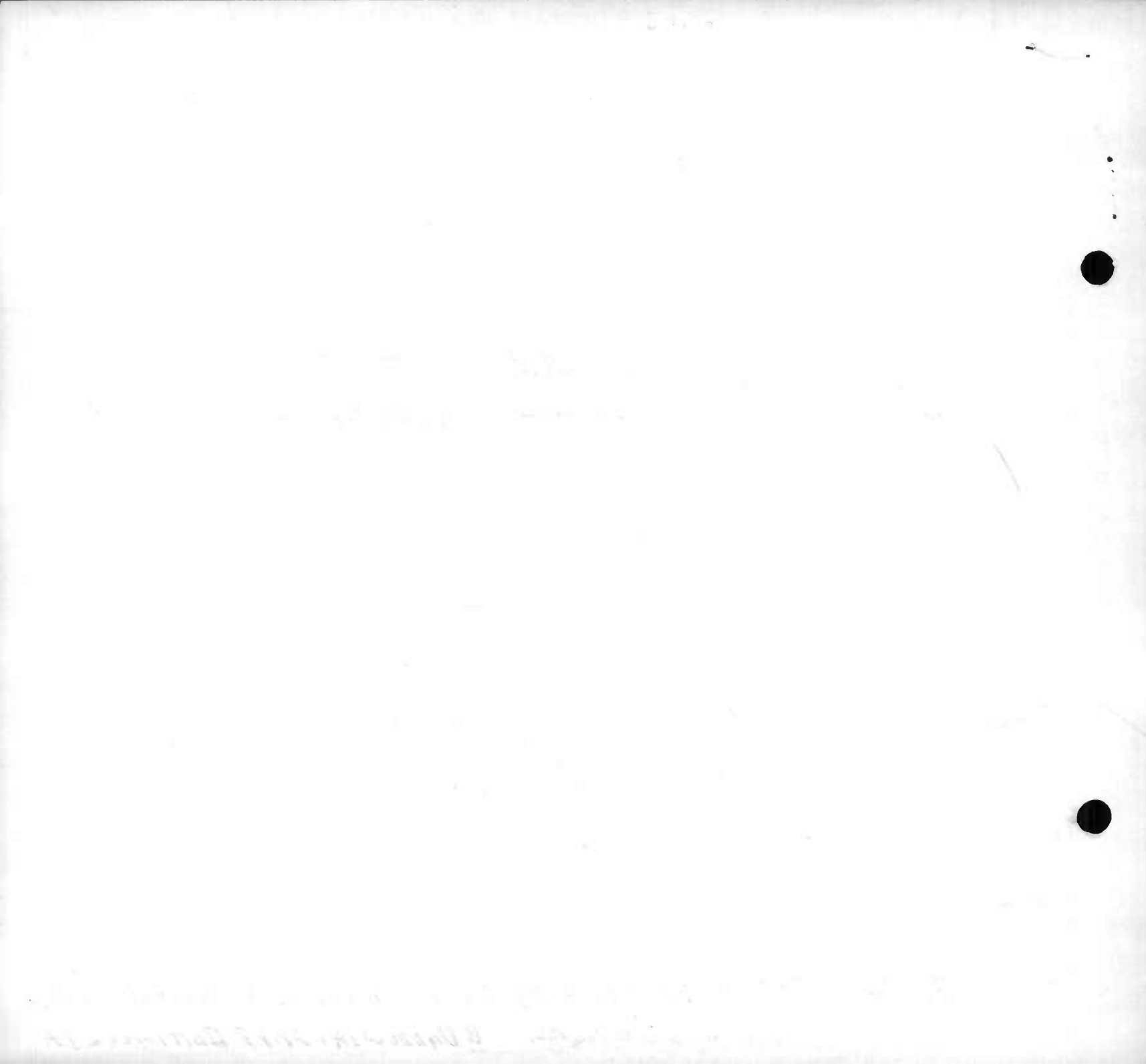
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2381 | |
|--|--|---|--|---|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) YASUKO MARUEL | | 2. DATE AND HOUR OF DEATH 3-6-71 6:45 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 Good SAMARITAN HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. CO. C. CITY OR TOWN EJSEK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 292 Stillwater Rd. 21221 | | |
| 5. SEX ♀ | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-14-1933 | 9. AGE (In years last birthday) 37 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE STREET | | | 10B. KIND OF BUSINESS OR INDUSTRY CLOTHING MER. | | |
| 11. BIRTHPLACE (State or foreign country) JAPAN | | | 12. CITIZEN OF WHAT COUNTRY? JAPAN | | |
| 13. FATHER'S NAME UNKNOWN | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 217-50-5359 | | |
| 17. INFORMANT ALAN MARUEL, 292 STILLWATER RD., 21221 | | | ADDRESS | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE Acute Renal failure DUE TO, OR AS A CONSEQUENCE OF: (B) Post necrotic cirrhosis. DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-6-1971 to 3-6-1971, that (I) (we) last saw the deceased alive on 3-5-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John C. Whelton MB. MRCP | | | | 23B. DATE SIGNED 3/6/71 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN C. WHELTON MB. BCh. MRCP. | | | | 23D. ADDRESS Good Samaritan Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9 MAR 71 | | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTO. CO., MD. | | 25A. DATE RECD BY HEALTH DEPT. MAR 10 1971 25B. NAME OF REGISTRAR G. E. F. F. F. 25C. FUNERAL DIRECTOR G. E. F. F. F. ADDRESS G. E. F. F. F. FUNERAL HOME, DUNDALK, MD. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|--------------------------------------|--|---|
| 71 2382 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2382 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) DEEMS PERRY | | 2. DATE AND HOUR OF DEATH MARCH 6TH 1971 12:50 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY 602 | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL 35 | | E. STREET AND NUMBER FAYETTE ST 2511 E | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-5-1867 | 9. AGE (In years last birthday) 103 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) W. VA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME JERRY DEEMS 232-36-6798 | | 14. MOTHER'S MAIDEN NAME - | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 1-02632 | | 17. INFORMANT Beulah Bailey 124 N. HAVEN ST | |
| 18. E880X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE SUB-DURAL HAEMATOMA DUE TO, OR AS A CONSEQUENCE OF: (B) HEAD INJURY DUE TO, OR AS A CONSEQUENCE OF: (C) - | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 3/5/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2511 E. FAYETTE | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 1:45 PM 3/5/71 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? FELL DOWN STAIRS | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/5/71 19 to 3/6/71 19 that (I) (we) lost saw the deceased alive on 3/6/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE T. SKEE RAMAMURTHY | | 23B. DATE SIGNED 3/6/71 | | 23C. PHYSICIAN'S NAME (Type) T. SKEE RAMAMURTHY | |
| 23D. ADDRESS - | | 23E. PHYSICIAN'S DEGREE - | | 23F. PHYSICIAN'S ADDRESS - | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-9-71 | | 24C. NAME OF CEMETERY OR CREMATORY BEVERLY HILLS CEM. | |
| 24D. LOCATION (City, town, or county) (State) MORGANTHA CO. WEST VIRGINIA | | 24E. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 24F. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 24G. FUNERAL DIRECTOR B. Dabrowski | | 24H. ADDRESS 2818 E. BALTIMORE ST. | | 24I. DATE - | |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | 71 2383 | | REG. NO. 71 2383 | |
|--|---------------------|---|--|--|--|---|--|
| BIRTH NO. K-152 | | 71 2383 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Kenneth O. Robinson | | | | 2. DATE AND HOUR OF DEATH 3/8/71 4:02 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Md. | | B. COUNTY XXXXX XXXX | |
| | | | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 5408 Remmell Ave. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/11/13 | | 9. AGE (in years last birthday) 57 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Safety Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY Steel Co. | | 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Robinson | | | | 14. MOTHER'S MAIDEN NAME Alice ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 177-05-9739 | | 17. INFORMANT Mrs. Evelyn O. Robinson | | ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC HEART DYS. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC HEART DYS. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Victor R. Felipa M.D. | | | | 23B. DATE SIGNED 3/8/71 | | 23C. PHYSICIAN'S NAME (Type) Victor R. Felipa M.D. | |
| 23D. ADDRESS Maryland General Hospital | | 23E. NAME OF REGISTRAR Leonard J. Ruck, Inc. | | 23F. FUNERAL DIRECTOR Balto. Md. 21214 | | 23G. ADDRESS Balto. Md. 21214 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/12/71 | | 24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. | | 25C. FUNERAL DIRECTOR Balto. Md. 21214 | | 25D. ADDRESS Balto. Md. 21214 | |



S-616

71 2384 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2384

BIRTH NO.

Schreiber

1. NAME OF DECEASED
(Type or Print)

DANIEL SCHREIBER

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3021 E. Northern Parkway

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

March 6, 1971

6:30 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2745

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Oct. 3, 1893.

10. AGE (In years
lost birthday)

77

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3021 E. Northern Parkway

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

? Schreiber

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

Western Electric

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

215-03-9629

18. INFORMANT

Meisner Funeral Home,

ADDRESS

5624 Irving Park Rd.
Chicago, Ill.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Shotgun wound of trunk
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3021 E. Northern Parkway

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY 3-5-71 or
(APPROX.) 3-6-71 ? m.22E. INJURY OCCURRED
WHILE AT WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot self

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Charles S. Springate, M.D.
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 7, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/13/71

24C. NAME of CEMETERY or CREMATORY

Rosehill Cem.

24D. LOCATION

(City, town, or county) (State)

Chicago, Cook Co. Ill.

25A. DATE REC'D BY HEALTH DEPT.

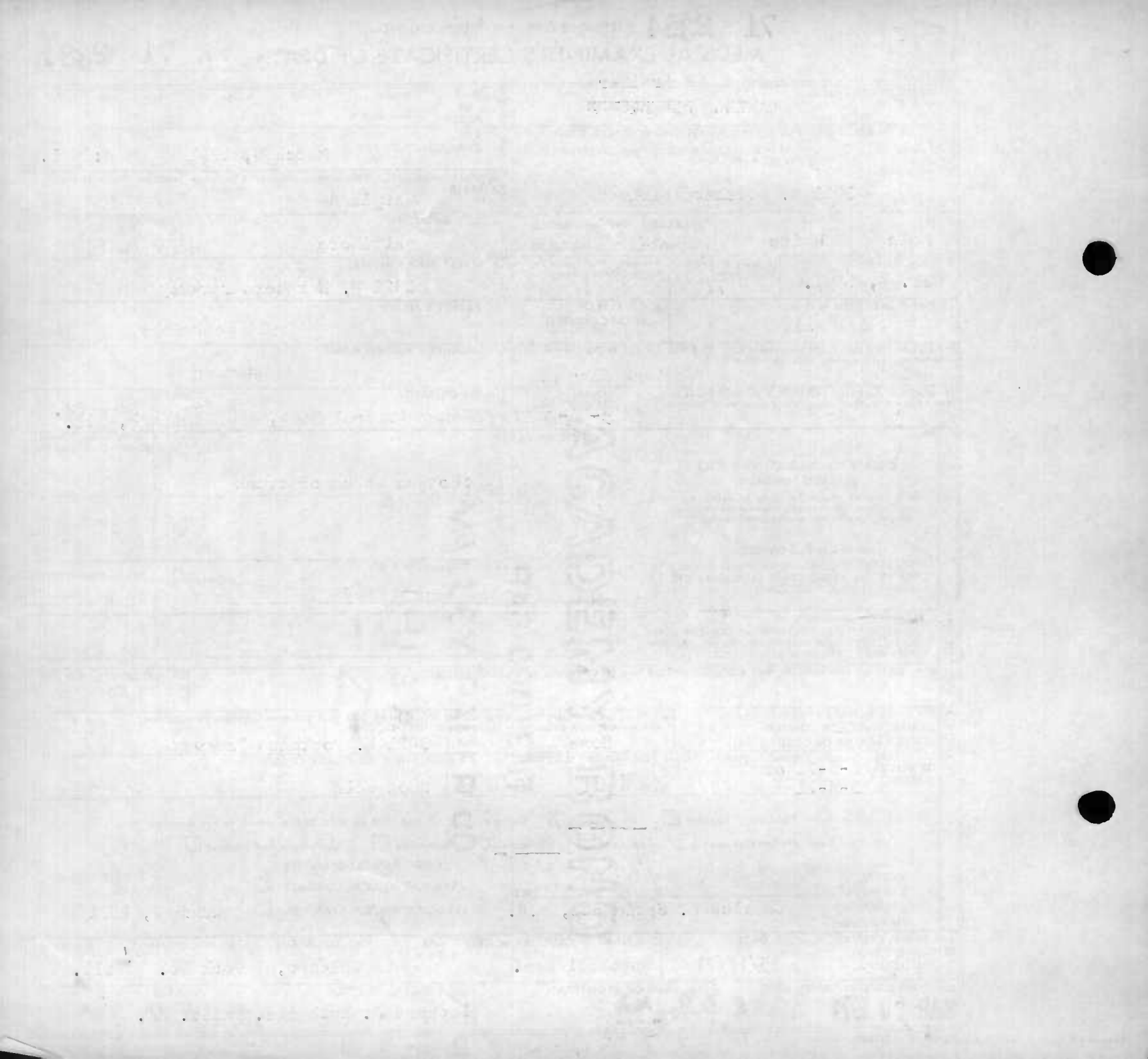
MAR 10 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

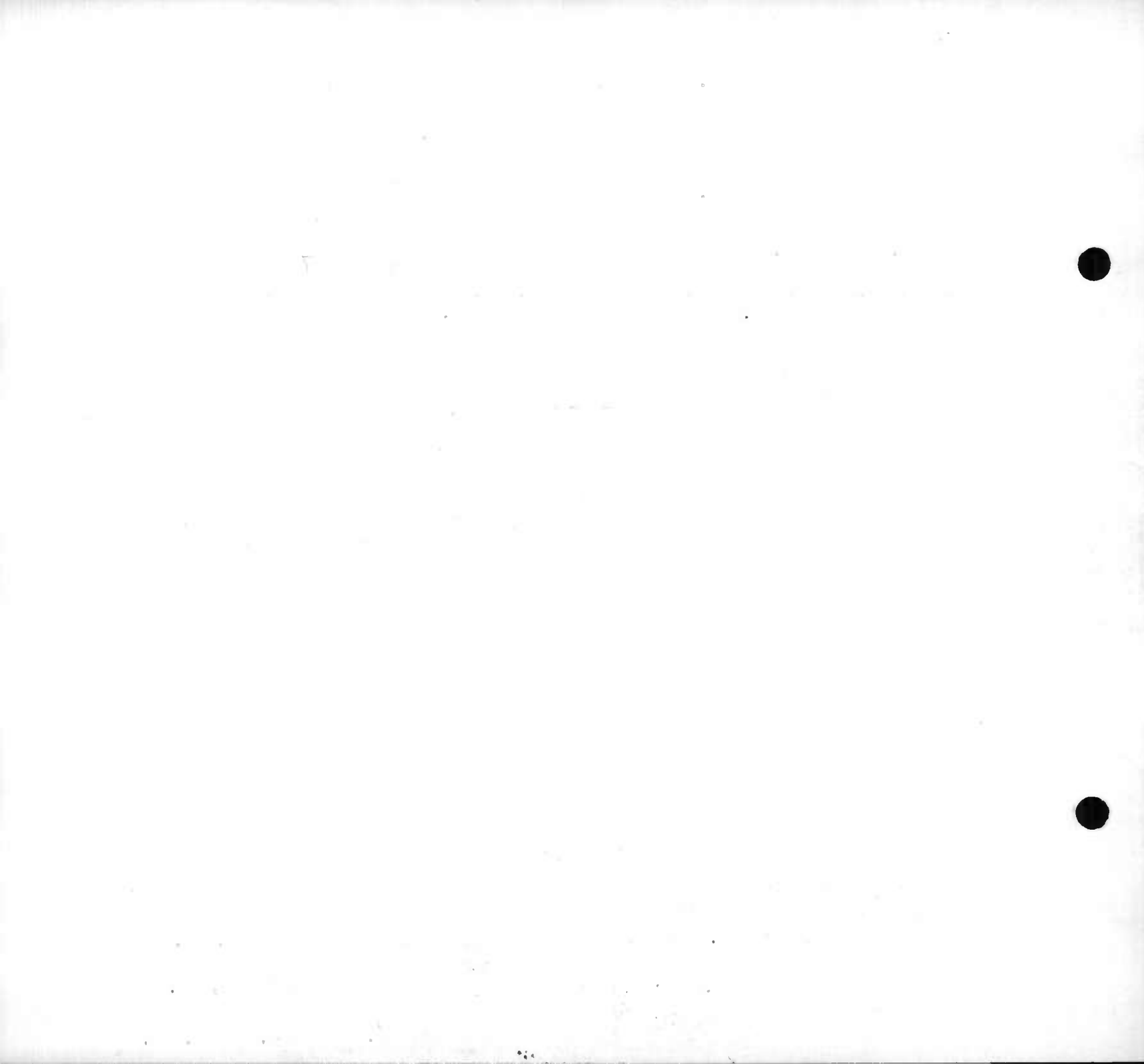
Leonard J. Ruck Inc. Balto. Md.



*under regular care Dr. Donald W. Mintzer
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2385 | |
|---|------------|--|---------------------------------|--|--|
| BIRTH NO. V-523 71 2385 | | | | | |
| 1. NAME OF DECEASED (Type or Print) William F. Vomastek | | 2. DATE AND HOUR OF DEATH 3/11/71 3:00 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2810 White Ave. | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2706 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2810 White Ave. | | | |
| 5. SEX M. | 6. RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 10, 1913 | 9. AGE (In years last birthday) 57 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas & Electric Co. Investigator | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME James Vomastek | | 14. MOTHER'S MAIDEN NAME Mary Fuka | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes | | 16. SOCIAL SECURITY NO. 212-05-3083 | | 17. INFORMANT Mrs. Ruth Vomastek ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH ACUTE MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: FACULTY DUE TO (B) DUE TO, OR AS A CONSEQUENCE OF: DISEASE (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 3/10/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donald W. Mintzer MD | | 23B. DATE SIGNED 3/8/71 | | 23C. PHYSICIAN'S NAME (Type) Donald W. Mintzer MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/71 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Sabin | |
| 25C. FUNERAL DIRECTOR Leonard J. Buck Inc. Balto. Md. | | 25D. ADDRESS | | 25E. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|-------------------------------------|---|--|
| B-424 71 2386 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2386 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Alice Blackwell</u> | | 2. DATE AND HOUR OF DEATH <u>3/8/71 11:01 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1604</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Lake Drive Nursing Home</u> <u>3401 Eutaw Place</u> <u>Baltimore, Md. 21217</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>920 N. Fulton Ave</u> | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-4-1900</u> | 9. AGE (in years last birthday) <u>70yrs.</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>No. Umberland Cty., Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | |
| 13. FATHER'S NAME <u>Hiddie Blackwell</u> | | 14. MOTHER'S MAIDEN NAME <u>Fannie</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>212-18-0402</u> | | 17. INFORMANT <u>Mrs. Mary Dates (Sister)</u> ADDRESS <u>1033 N. Mount St. - Balto.</u> | |
| 18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Inerm negative Bacteriemic Shock</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA + urinary tract infection</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Ascid.</u> (C) _____ | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-31</u> 19 <u>71</u> to <u>3-8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3-5</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | 23B. DATE SIGNED <u>3-8-71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>James F. McVernae</u> | | 23D. ADDRESS <u>8935 Pipers Path Glen Burnie Md 21061</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE <u>3/13/71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Int. Calverly Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1971</u> | 25B. NAME OF REGISTRAR <u>John E. [Signature]</u> | 25C. FUNERAL DIRECTOR <u>John E. [Signature]</u> | | ADDRESS <u>1604</u> | |

CERTIFICATE OF DEATH

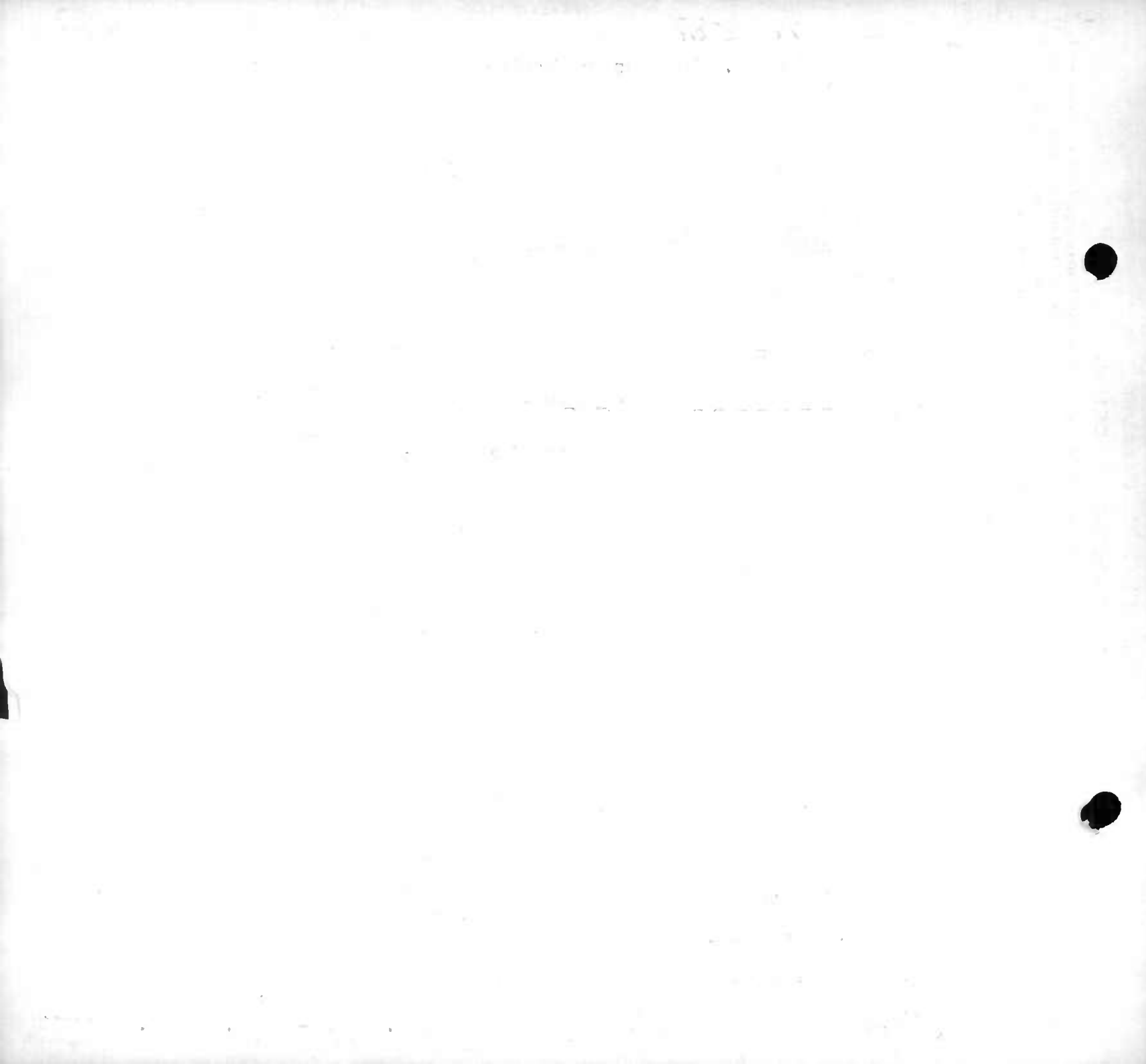
REG. NO.

71 2387

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

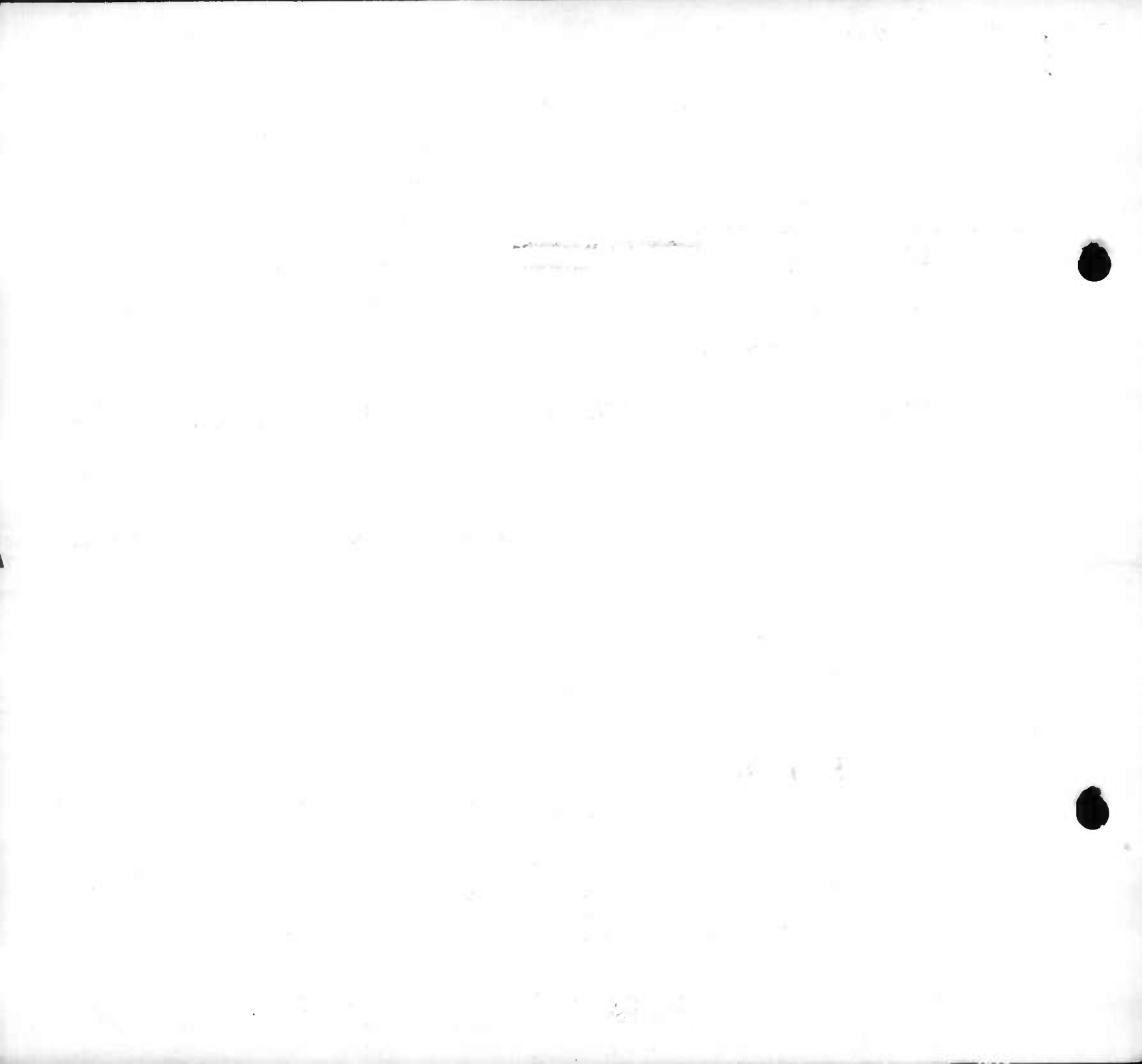
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|--|----------------------|---|--|---|---|--|--|
| BIRTH NO. S-362 | | 71 2387 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2387 | |
| 1. NAME OF DECEASED (Type or Print) Edward J. Strychacz or Strychac | | | | 2. DATE AND HOUR OF DEATH 3/9/71 8:00 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 312 German Hill Road 21222 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-4-15 | 9. AGE (In years last birthday) 55 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipsealer | | 10B. KIND OF BUSINESS OR INDUSTRY Longshoreman | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Strychacz | | | | 14. MOTHER'S MAIDEN NAME Jadwiga Dziubek | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-01-7851 | | 17. INFORMANT 4940 Eastern Avenue ADDRESS Baltimore, Maryland 21224 BCH: Records | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiopulmonary Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last Etiology unknown II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Probable Rheumatic Heart Disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0-5 mins. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW OLD INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 3/9/71 19 to 3/9/71 19 that (1) (we) last saw the deceased alive on 3/9/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE W. Lowell M.D. | | | | 23B. DATE SIGNED March 9, 1971 | | 23C. PHYSICIAN'S NAME (Type) W. Lowell M.D. | |
| 23D. ADDRESS 4940 Eastern Avenue | | 23E. CITY, TOWN, OR COUNTY Baltimore, Maryland | | 23F. STATE 21224 | | 23G. ZIP CODE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/12/71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery | | 24D. LOCATION (City, town, or county) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR George A. Weber | | 25D. ADDRESS 705 S. Ann St. #21231 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

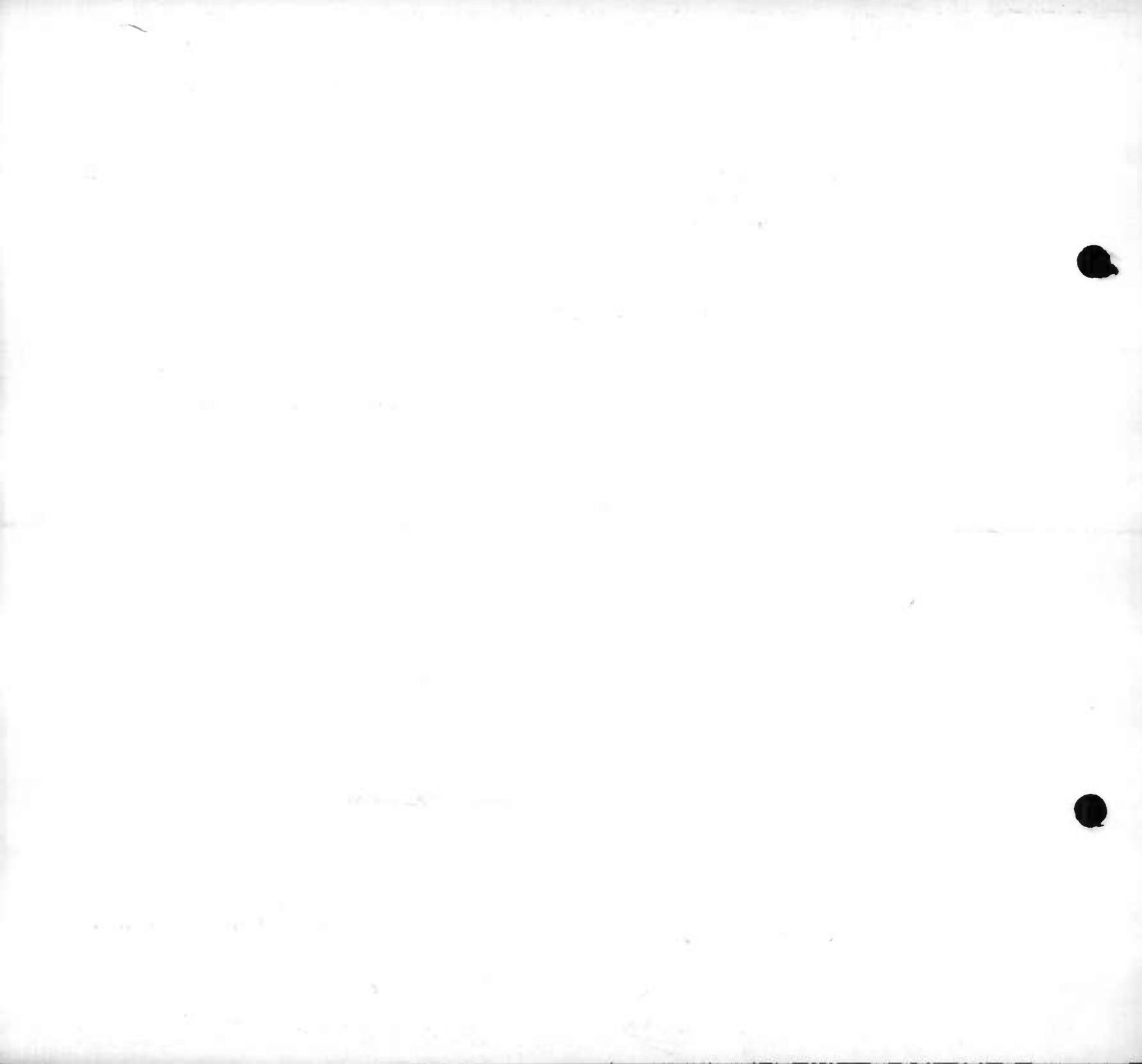
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|---|------------------|--|---------------------------------|---|--|---|--|
| BIRTH NO. <u>71 2388</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | 71 2388 | |
| BIRTH NO. <u>71 2388</u> | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 2388</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>Harold Zeigafuse</u> | | | | 2. DATE AND HOUR OF DEATH <u>3-7-71</u> <u>9:40</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD. (21222)</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>DUNDALK</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>46 Vista Mobile Dr.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-11-10</u> | 9. AGE (In years last birthday) <u>60</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumberman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Timber</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>Gilbert ZEIGAFUSE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary GRUBE</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unk</u> | | 16. SOCIAL SECURITY NO. <u>174091563</u> | | 17. INFORMANT BCH RECORDS <u>Self</u> ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u> | | | |
| 18. <u>519.31</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Lung Disease</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u> <u>40 yr.</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>3-6-71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Venous Cutdown</u> | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>6</u> <u>12</u> <u>71</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>3-1</u> 19 <u>71</u> to <u>3-7</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>3-7</u> 19 <u>71</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Theodore G Rosem</u> DEGREE | | | | 23B. DATE SIGNED <u>3-7-71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Theodore G Rosem</u> DEGREE | |
| 23D. ADDRESS <u>Baltimore City Hospital</u> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-11-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>GRONS. FAITH</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Robert E. Taylor</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X REG. NO. 71 2389 | |
|---|-------------------------|---|---|---|--|
| T-130 71 2389 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) FRANK L. TOFT | | | 2. DATE AND HOUR OF DEATH 3/5/71 10:45 PM 10:45 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. BALTIMORE B. COUNTY 5300 C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 13 VINCENT AVE. 21221 | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/3/88 | 9. AGE (In years last birthday) 83 YEARS | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY SCRAP DEALER | | 11. BIRTHPLACE (State or foreign country) HOWARD COUNTY, MD | |
| 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | 13. FATHER'S NAME JAMES EDWARD TOFT | | |
| 14. MOTHER'S MAIDEN NAME JOSEPHINE MATTHEW | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. A 214-22-5154 | | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Ave. 21224 | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 10 1969 to MARCH 5th 1971 that (I) (we) last saw the deceased alive on 3/5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] M.D. | | | 23B. DATE SIGNED 3/5/71 | | 23C. PHYSICIAN'S NAME (Type) George R. Ayon M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | 24B. DATE 3-9-71 | | 24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM. |
| 24D. LOCATION (City, town, or county) (State) RITCHIE HIGHWAY, A.A.CO., MD. | | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | |
| 25B. NAME OF REGISTRAR Robert E. Faber | | | 25C. FUNERAL DIRECTOR Robert E. Faber | | |
| 25D. ADDRESS 6224 EASTERN AVE BALTO, 21224 MD. | | | 25E. ADDRESS 6224 EASTERN AVE BALTO, 21224 MD. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 71 2390 |
|--|--|---|--|---|---------|
| B-650 | | | | 71 2390 | |
| BIRTH NO. | | | | 71 2390 | |
| 1. NAME OF DECEASED (Type or Print) BROHAWN, MRS. ELAINE D. (Vera Hansen) | | | | 2. DATE AND HOUR OF DEATH March 9, 1971 5:05 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 4-2025 W. Fayette St. BALTIMORE, MD. 21223 | | A. STATE MD. B. COUNTY Baltimore | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 9/06/98 | | 9. AGE (In years last birthday) 72 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME CLIFTON DORSEY | |
| 14. MOTHER'S MAIDEN NAME Lilly BRATHAN | | 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) 218-09-1250 | | 16. SOCIAL SECURITY NO. 218-09-1250 | |
| 17. INFORMANT Irving L. Brohawn | | | | ADDRESS 701 N. Chapelgate Lane | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE Sudden Cardiac Arrest | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Acute Myocardial Infarction | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | (C) | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 7 19 71 to March 9 19 71 that (I) (we) last saw the deceased alive on March 9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Young Jai Lee | | 23B. DATE SIGNED March-9 1971 | |
| 23C. PHYSICIAN'S NAME (Type) YOUNG JAI LEE M.D. | | 23D. ADDRESS Bon Secours Hosp. BAL. Md. 21223 | | 23E. FUNERAL DIRECTOR Atzje, 1630 Edmondson Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/12/71 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park | |
| 24D. LOCATION Baltimore, Maryland | | 24E. CITY, town, or county 21229 | | 24F. STATE 21228 | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR E. J. J. J. | | 25C. FUNERAL DIRECTOR Atzje, 1630 Edmondson Avenue | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 8-460 71 2391 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 71 2391 | |
|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Schoeler, Karolina | | | | 2. DATE AND HOUR OF DEATH 3/9/71 7 Am M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) all of Md Hosp. Baltimore | | | | A. STATE Md B. COUNTY Baltimore | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> ? | |
| 5. SEX F 6. RACE Cauc 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 2/29/96 9. AGE (in years last birthday) 75 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ? 10B. KIND OF BUSINESS OR INDUSTRY ? | |
| 11. BIRTHPLACE (State or foreign country) Austria | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Johan Huber | | | | 14. MOTHER'S MAIDEN NAME Simon | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Pt's chart ADDRESS Mr. Werner Schoeler 111 Woodwind Road 21228 | |
| 18. 39.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio respiratory collapse 1-2hrs (B) Massive oral hemorrhage 2-3hrs (C) L. hemopharyngeal tumor 3-4 yrs | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 3/11/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED hemopharyngeal tumor | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White AI <input type="checkbox"/> Not White AI Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/28/71 19 71 to 3/9/71 19 71 that (I) (we) lost saw the deceased alive on 3/9/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Rolf Memon | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/9/71 | |
| 23C. PHYSICIAN'S NAME (Type) N/EMAN | | | | 23D. ADDRESS all of Md Hosp Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/11/71 | | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Sabin, M.D. | | 25C. FUNERAL DIRECTOR Witzke, 91610 | | ADDRESS Edmondson Avenue 21228 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2392</u> | |
|--|--------------------------------|---|--|---|---|
| BIRTH NO. <div style="font-size: 2em; float: left; margin-right: 10px;">1-200</div> <div style="font-size: 2em; float: left; margin-right: 10px;">71</div> <div style="font-size: 2em; float: left;">2392</div> <div style="clear: both;"></div> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED <small>(Type or Print)</small> LEASE, Lloyd H. | | | 2. DATE AND HOUR OF DEATH 3-9-71 3:20 <small>A.M.</small> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <small>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | 4. USUAL RESIDENCE <small>(Where deceased lived. If institution: residence before admission)</small> A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 634 S. Leight Street | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 5-12-00 | 9. AGE <small>(In years last birthday)</small> 70 | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> 10B. KIND OF BUSINESS OR INDUSTRY Steel | | 11. BIRTHPLACE <small>(State or foreign country)</small> Creasptown, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Walter Lease | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> Yes 5-17-17 to 3-18-19 | | 16. SOCIAL SECURITY NO. 217-10-18-68 | | 17. INFORMANT VA Hospital Records Baltimore, Maryland 21218 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE Respiratory failure DUE TO, OR AS A CONSEQUENCE OF: (B) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF: (C) Carcinoma of lung | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years 5 years | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | |
| 19A. DATE OF OPERATION 2-2-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? <small>(Yes or No)</small> YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <small>(notify medical examiner)</small> <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small> | | 21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small> | | | |
| 21D. TIME OF INJURY <small>(Month) (Day) (Year) (Hour)</small> (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that XX <small>(this hospital)</small> attended the deceased from February 25, 19 71 to March 9, 19 71 that XX <small>(we)</small> last saw the deceased alive on March 9, 19 71 and that in XX <small>(my)</small> our opinion death occurred on the date and hour and from the causes stated above. XX <small>(We)</small> (did) not view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED 3/9/71 | | 23C. PHYSICIAN'S NAME <small>(Type)</small> JOHN F. ROGERS, M.D. |
| 24A. BURIAL, CREMATION, REMOVAL <small>(Specify)</small> BURIAL | | | 24B. DATE 3-11-71 | | 24C. NAME OF CEMETERY OR CREMATORY CULPPER NATIONAL |
| 24D. LOCATION <small>(City, town, or county)</small> <small>(State)</small> Baltimore, Maryland 21218 | | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR <small>ADDRESS</small> Gradesk B. Cook 7200 Harbor Rd | | | |

634. S. Lehigh (sister's address)
unable to get Permanent Address

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2393 | |
|--|--|--|---|--|--|
| # 623 71 2393 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Artha Ellen Hargett | | 2. DATE AND HOUR OF DEATH 3-4-71 12:15 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN 1803 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 11 S. Carey Street | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-18-18 | 9. AGE (In years last birthday) 52 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Tenn. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME — James Presell | | | |
| 14. MOTHER'S MAIDEN NAME Della Birch Sield | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. 409-22-6516 | | 17. INFORMANT Willis Calhoun ADDRESS 115. Carey St. Balt. 21223 | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF: Alcoholic induced Chronic alcoholism (B) Staphylococcal pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-16-71 19 71 to 3-4- 19 71 that (I) (we) last saw the deceased alive on 3-4-71 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H.H. Briele, Jr. MD | | 23B. DATE SIGNED 3-4-71 | | 23C. PHYSICIAN'S NAME (Type) H.H. Briele, Jr. MD | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE 3-8-71 | | 24C. NAME OF CEMETERY OR CREMATORY Greenland Cemetery | |
| 24D. LOCATION (City, town, or county) Erwin, Tenn. | | 24E. FUNERAL DIRECTOR George L. Schumb F.H. 2161 | | 24F. ADDRESS Frederick Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Kelly, Jr. | | 25C. FUNERAL DIRECTOR George L. Schumb F.H. 2161 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2394 | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>Nicol-William</u> | | 2. DATE AND HOUR OF DEATH <u>3-8-71- 3 AM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Harborview Nursing Home</u> <u>3-15-71</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> 5. CITY OR TOWN <u>BALTIMORE MD</u> 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER <u>1939 Ramsey Ave.</u> <u>1430 Ramsey Ave.</u> | | | |
| 8. SEX <u>Male</u> | | 9. RACE <u>White</u> | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 11. WIDOWED <input checked="" type="checkbox"/> 12. DIVORCED <input type="checkbox"/> | |
| 13A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | | 13B. KIND OF BUSINESS OR INDUSTRY <u>Mechanist</u> | | 14. DATE OF BIRTH <u>12-29-85</u> | |
| 15. FATHER'S NAME <u>Henry Otto</u> | | 16. MOTHER'S MAIDEN NAME <u>Marie Zimmer</u> | | 17. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | |
| 18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u> | | 19. SOCIAL SECURITY NO. <u>21607 7661A</u> | | 20. INFORMANT <u>Daughter - Mrs. Lydia Kencel</u> | |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <u>440191</u> 22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Brachio pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | 23. CITIZEN OF WHAT COUNTRY? <u>BALTO. CITY</u> 24. ADDRESS <u>1939 Ramsey St. Baltimore 21223</u> 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 26A. DATE OF OPERATION <u>3-11-71</u> | | 26B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brachio pneumonia</u> | | 26C. AUTOPSY? (Yes or No) <input type="checkbox"/> | |
| 27A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <u>No</u> (If yes, specify medical examiner) | | 27B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 27C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 28A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 28B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 28C. HOW DID INJURY OCCUR? | |
| 29. I certify that (I) (this hospital) attended the deceased from <u>November 8, 1969</u> to <u>March 8, 1971</u> that <u>we</u> last saw the deceased alive on <u>March 8, 1971</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>we</u> (We) (did) (did not) view the body after death. | | | | | |
| 30A. SIGNATURE <u>Adonacion B. Paulino</u> | | 30B. DATE SIGNED <u>March 8, 1971</u> | | 30C. PHYSICIAN'S NAME (Type) <u>Adonacion B. Paulino</u> | |
| 31A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 31B. DATE <u>3-11-71</u> | | 31C. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> | |
| 32A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1971</u> | | 32B. NAME OF REGISTRAR <u>George E. Schwab</u> | | 32C. FUNERAL DIRECTOR <u>2101 Frederick Ave</u> | |

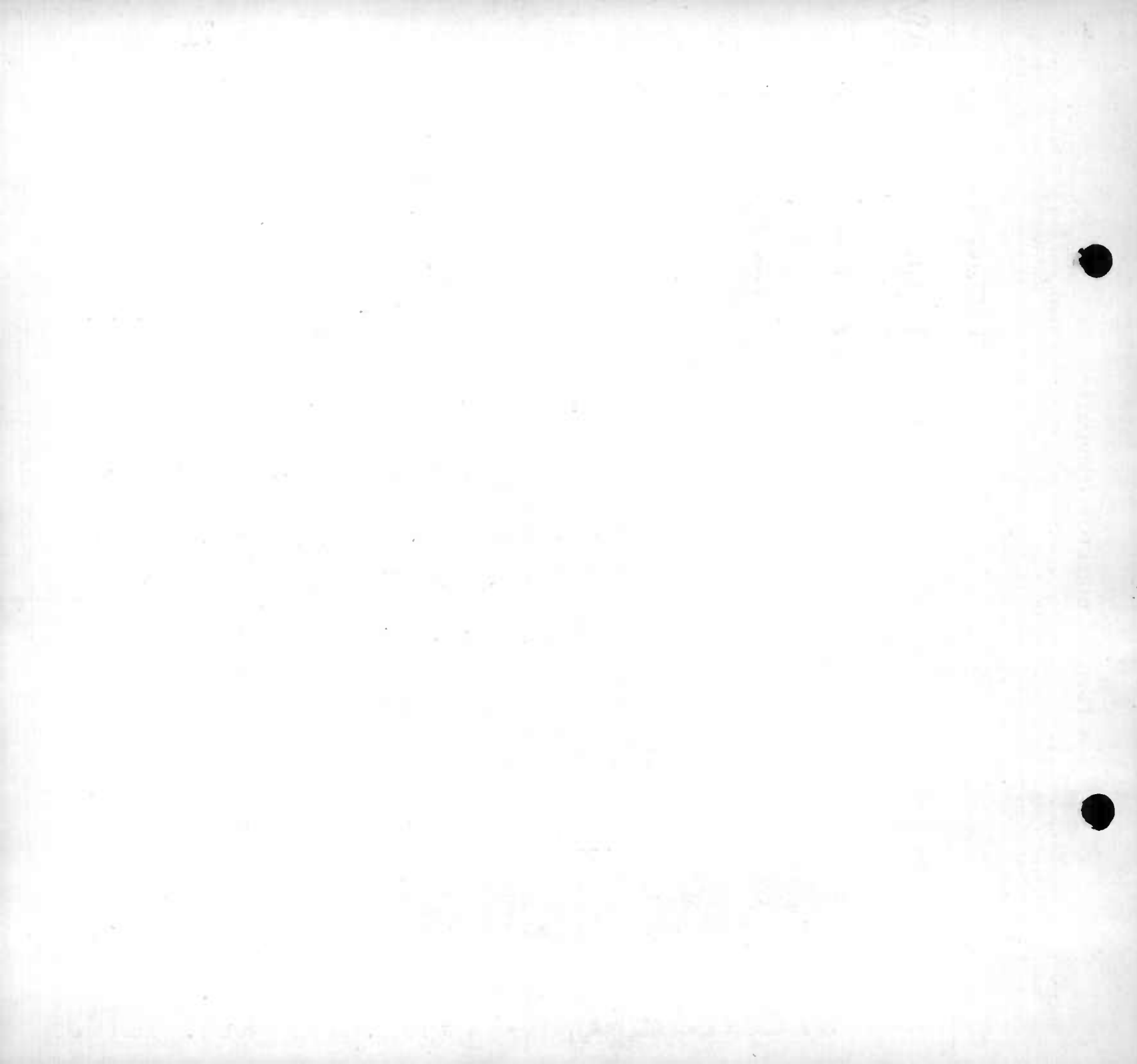
V.S. 153

3-15-71

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

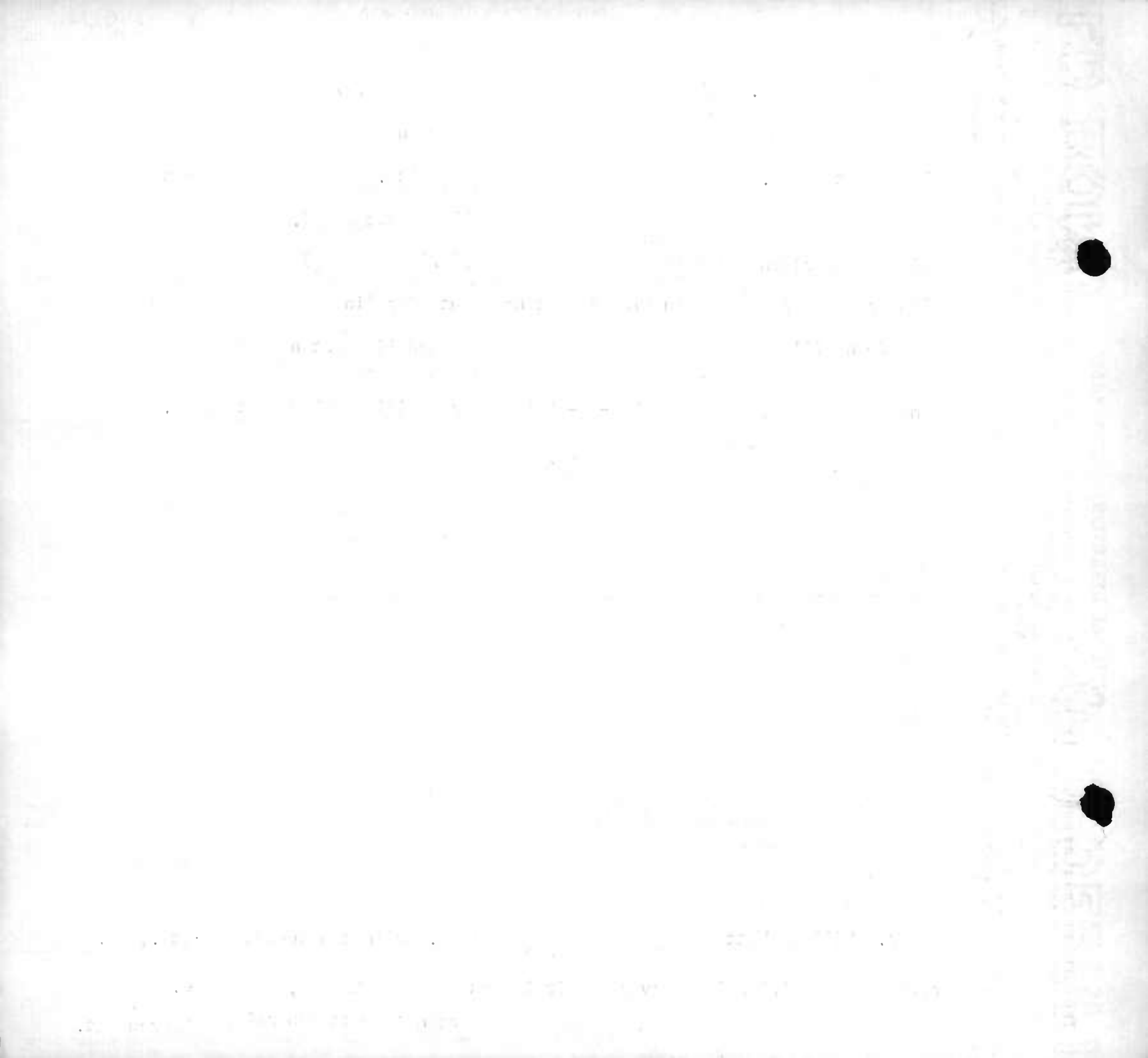
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2395 |
|---|----------------------------|---|---|---|
| 1. NAME OF DECEASED (Type or Print) Stella Marciszewski | | 2. DATE AND HOUR OF DEATH March 10, 1971 2:00A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 1) Gould Conv. Home | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY 2642 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4205 Seidel Ave. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 30 1895 76 9. AGE (In years last birthday) 76 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | | 11. BIRTHPLACE (State or foreign country) Poland 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Lewandowski | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 205-16-6348 | 17. INFORMANT ELEANOR LAPINSKI | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/12/31 + 250.9 CAUSE OF DEATH Acute Bronchopneumonia 1 day | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Congestive Heart Failure months (B) Chronic Congestive Heart Failure years (C) Chronic Brain Syndrome; Metastatic; Diabetes; Uremia; Multiple Aneurysms; | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 3/10/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic Brain Syndrome; Metastatic; Diabetes; Uremia; Multiple Aneurysms; | | 20A. AUTOPSY? (Yes or No) No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/3/19 71 to 3/10/19 71 , that (I) (we) last saw the deceased alive on 3/9/19 71 and that in (my) (our) opinion death occurred on the date 3/10/19 71 and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Albert B. Bradley | | 23B. DATE SIGNED 3/10/71 | | 23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY, M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/71 24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cem 24D. LOCATION (City, town, or county) (State) Dundalk, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR John M. Weber | | |
| 25C. FUNERAL DIRECTOR John M. Weber | | ADDRESS 401 S. Chester St | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2396 | |
|---|----------------------------|---|--|---|---|
| BIRTH NO. 71 2396 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) THEODORE N. HILL | | | 2. DATE AND HOUR OF DEATH 3/8/71 M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1511 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3708 Chatham Rd. 00 | | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 3708 Chatham Rd. | | |
| 5. SEX Male | 6. RACE American | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/16/1900 | 9. AGE (In years last birthday) 70 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbers Helper | | 10B. KIND OF BUSINESS OR INDUSTRY Plumbing & Heating | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME John Hill | | | 14. MOTHER'S MAIDEN NAME Ophelia Boston | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 215-07-0351 | 17. INFORMANT ADDRESS Dora Hill 3708 Chatham Rd. | | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute coronary occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3 years | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-10-1968 to 3-8-71 19 that (I) (we) last saw the deceased alive on 1-4-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William Watts | | | 23B. DATE SIGNED 3/10/71 | | 23C. PHYSICIAN'S NAME (Type) Dr. William Watts |
| 23D. ADDRESS 515 N. Arlington Avenue Balto., Md. | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 3/12/71 | | 24C. NAME of CEMETERY or CREMATORY Carver Memorial Park | | 24D. LOCATION (City, town, or county) (State) Laurel, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR 26 DE J. B. ... | | 25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett Funeral Home Laurens St. | |



138 7758
BOURNE SR., THOMAS
09 24 99

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65071 2397 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2397 | |
|--|-------------------------|---|------------------------------------|--|------------------------|---|------------------------|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) THOMAS H. BOURNE SR. | | | | 2. DATE AND HOUR OF DEATH 3-2-71 1745 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1304 | | | |
| | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 2316 WHITTIER AVE. | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-24-99 | 9. AGE (in years last birthday) 71 | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Calvert Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME EDWARD D. BOURNE | | | | 14. MOTHER'S MAIDEN NAME ANNIE Howell | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 219-20 2049 | | 17. INFORMANT Ms. Elizabeth Bourne ADDRESS 2316 Whittier Ave. | | | |
| 18. 038171 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Renal Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Gram negative sepsis DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2-1-24-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Appendiceal Abscess | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-1-71 to 3-2-71 that (I) (we) last saw the deceased alive on 3-2-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Joseph O. Moore MD DEGREE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-2-71 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH O. MOORE DEGREE | | | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-71 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Yerpoort (Baltimore) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Sabin, MD | | 25C. FUNERAL DIRECTOR Joseph R. Brown | | ADDRESS 2222 N. North Ave. | |

STANDARD

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July 1 1901

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July 1 1901

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2398 | |
|---|-------------------------|--|--|--|---|
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) Hester Davis | | | 2. DATE AND HOUR OF DEATH 3/2/71 6:15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Good Samaritan Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2418 Montebello Terrace 21214 | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 9-25-02 | 9. AGE (In years last birthday) 68 yr. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Miss. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | 13. FATHER'S NAME Jerry Davis | | |
| 14. MOTHER'S MAIDEN NAME Mary Marshall | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. 428-03-3767 | | | 17. INFORMANT Mr. Thelma Rose | | |
| 18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarct | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Infarct DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). hypertension & asthma | | | (C) _____ | | |
| 19A. DATE OF OPERATION 3/2/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/24 19 71 to 3/2 19 71 , that (I) (we) last saw the deceased alive on 3/2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard J. Owellen | | | 23B. DATE SIGNED 3/2/71 | | 23C. PHYSICIAN'S NAME (Type) Richard J. Owellen, M.D. |
| 23D. ADDRESS The Good Samaritan Hospital | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 3-6-71 | | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | |
| 24D. LOCATION (City, town, or county) Westport Baltimore Md. | | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | |
| 25B. NAME OF REGISTRAR Robert E. Parker, M.D. | | | 25C. FUNERAL DIRECTOR Joseph G. Russ | | |
| 25D. ADDRESS 2222 W. Montebello | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. <u>71 2399</u> | |
|---|-------------------------|---|--|--|--|---|--|--|--|--|--|
| BIRTH NO. <u>8-536</u> | | 71 2399 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>SAUNDERS, Dr. LE ROY W.</u> | | | | 2. DATE AND HOUR OF DEATH <u>March 9, 1971 10:30 p. M.</u> | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2712</u> | | | | | | | |
| | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| | | | | E. STREET AND NUMBER <u>216 Goodale Road</u> | | | | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-29-98</u> | 9. AGE (In years last birthday) <u>72</u> | 11. Under 1 Yr. Months Days | | 12. Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Doctor - medicine</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>COLEMAN N. Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. (American)</u> | | | |
| 13. FATHER'S NAME <u>James Saunders</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Theodosia Snell</u> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WWI 212-05-6670</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Dorothy Saunders</u> ADDRESS <u>same</u> | | | | | |
| 18. <u>20571</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>possible apoplexy</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Myelogenous Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>3-12-1971</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>March 9</u> 19 <u>71</u> to <u>March 9</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>March 9</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>John Oke</u> MD DEGREE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>March 9, 1971</u> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Tohru OHE</u> MD DEGREE | | | | 23D. ADDRESS <u>Union Memorial Hospital</u> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-12-1971</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Dulaney Valley Memorial Gardens</u> | | 24D. LOCATION (City, town, or county) (State) <u>Timonium, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u> | | 25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> | | ADDRESS <u>2300 York Road Balto., Md. 21212</u> | | | | | |



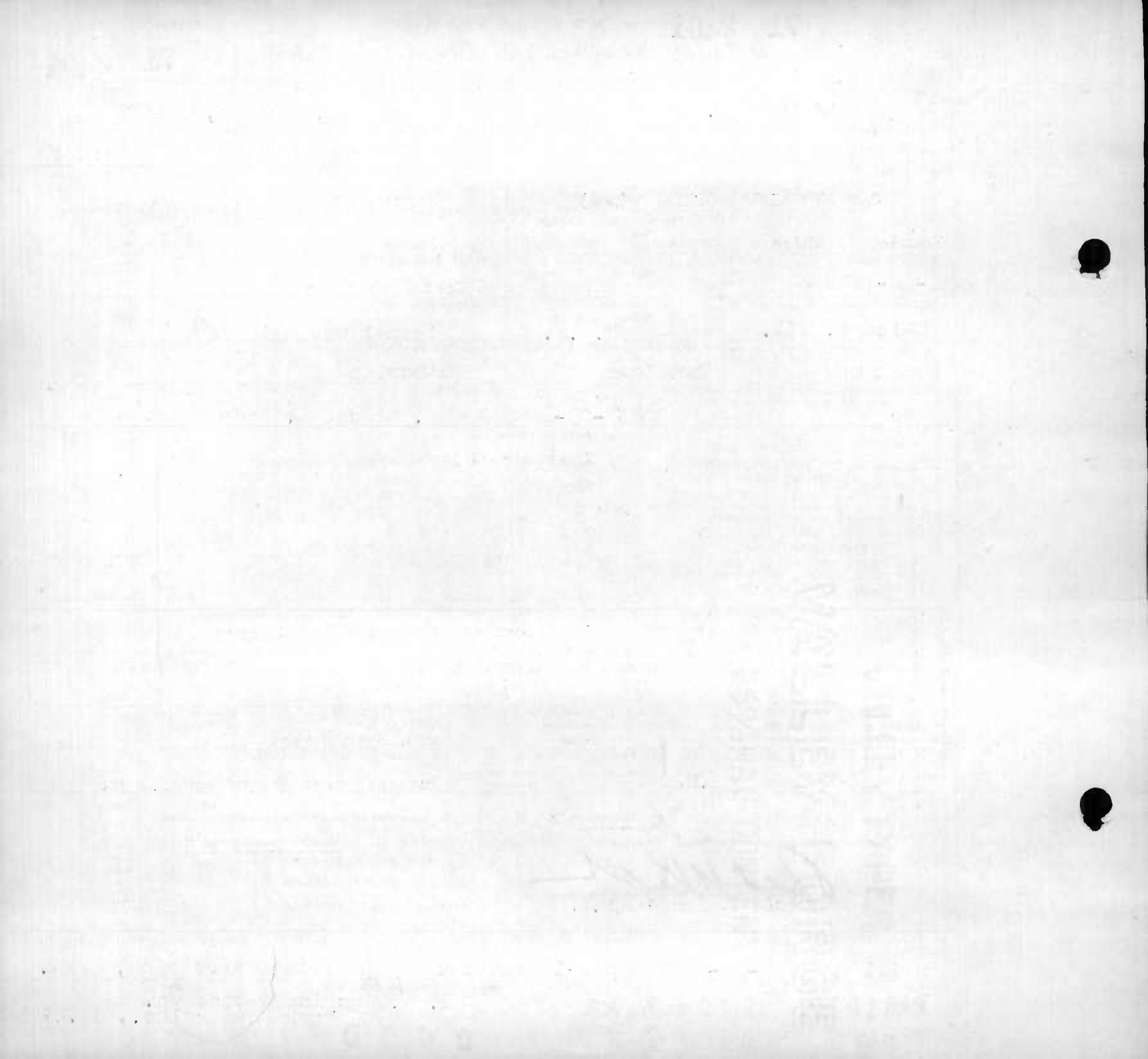
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2400</u> |
|---|--|--|--|-------------------------|
| BIRTH NO. <u>V-360 71 2400</u> | | 1. NAME OF DECEASED (Type or Print) <u>Vawter, Jesse A.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bolton Hill Nursing & Convalescent Ctr.</u> | | 2. DATE AND HOUR OF DEATH <u>March 8, 1971</u> <u>5:00 A.M.</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Bolton Hill Nursing & Convalescent Ctr.</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2711</u> | | |
| 5. SEX <u>M</u> 6. RACE <u>White</u> | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | E. STREET AND NUMBER <u>14 W. Coldspring Lane</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u> | | 8. DATE OF BIRTH <u>8-8-99</u> 9. AGE (In years last birthday) <u>71</u> | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u> | | 11. BIRTHPLACE (State or foreign country) <u>Indiana</u> | | |
| 13. FATHER'S NAME <u>Fred Vawter</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 14. MOTHER'S MAIDEN NAME <u>Stella Critchlow</u> | | |
| 16. SOCIAL SECURITY NO. <u>217-05-6704</u> | | 17. INFORMANT <u>Mrs. Beverly V. Diaz, 14 W. Coldspring Lane</u> <u>Admission Record</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>arteriosclerosis</u> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>yes</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>generalized arteriosclerosis</u> | | (B) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>yes</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Secretitis</u> | | (C) <u>Secretitis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>months</u> | | |
| 19A. DATE OF OPERATION <u>3/10/71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>11/89</u> 19 <u>71</u> to <u>3/8</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>3/8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | 23B. DATE SIGNED <u>3/9/71</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MARCH MD</u> | | 23D. ADDRESS <u>2 E. Red St Baltimore Md.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>3/10/71</u> | | |
| 24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | |
| 25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> | | ADDRESS <u>4905 York Rd. Balto., Md. 21212</u> | | |



| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MARGARET N. GRAY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 8, 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 8, 1971 6:05 P.M. | |
| 6. SEX Female | | 7. RACE White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 2-28-1898 | | 10. AGE (In years lost birthday) 73 | |
| 11. BIRTHPLACE (State or foreign country) Chicago, Ill. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 14B. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 217-03-4995 | |
| 18. INFORMANT Mr. Biscoe L. Gray | | ADDRESS Same | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E980.0 Overdose of Barbiturate | | CAUSE OF DEATH Overdose of Barbiturate | |
| 20. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 6 W. 39th Street | | 22D. TIME (Month) (Day) (Year) (Hour) 3-8-71 P.M. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Ingested overdose of barbiturate | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | DATE SIGNED 3/9/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-12-1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Central Cemetery | | 24D. LOCATION (City, town, or county) (State) Prince Frederick, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. | | ADDRESS 4905 York Road Balto., Md. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2402</u> | |
|--|---------------------|---|--|--|--|
| T-200 | | 71 2402 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Tosh, Lula M.</u> | | | 2. DATE AND HOUR OF DEATH <u>3/6/71 15:30 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2733</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>441 Union Memorial Hospital</u> | | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | E. STREET AND NUMBER <u>5134 Harford Rd</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>02-08-01</u> | 9. AGE (In years last birthday) <u>70</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME <u>Filden Lindamood</u> | | | 14. MOTHER'S MAIDEN NAME <u>Ollie Blessing</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Charles S. Ceciw 5401 Buckwell Rd.</u> |
| 18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/4</u> 19 <u>71</u> to <u>3/6</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/6</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>J. Cheik</u> | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>3/7/71</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>ISSAM CHEIKH</u> | | | 23D. ADDRESS <u>Union Memorial Hosp.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-9-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>West Nottingham</u> <u>Presbyterian Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>PORT DEPOSIT MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. J. ...</u> | | 25C. FUNERAL DIRECTOR <u>B. Dabrowski 2818 E. BALTIMORE ST.</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 2403 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X REG. NO. 71 2403 | |
|---|--|---|---|
| 1. NAME OF DECEASED (Type or Print) Burnell Calvin Utz | | 2. DATE AND HOUR OF DEATH 3/4/71 1135 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Carmel | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hosp. | | C. CITY OR TOWN Westminster | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/7/25 9. AGE (in years last birthday) 45 If Under 1 Yr. Months Days If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 10B. KIND OF BUSINESS OR INDUSTRY Meat Packing | | 12. CITIZEN OF WHAT COUNTRY? United States | |
| 13. FATHER'S NAME Theodore Utz | | 14. MOTHER'S MAIDEN NAME Goldie R. Zepp | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II | | 16. SOCIAL SECURITY NO. 220-18-1207 | |
| 17. INFORMANT Edna Utz (Wife) | | ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia - bilateral 2 wks | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bone Marrow Failure 6 wks | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Myelogenous Leukemia 14 wks | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION 3/4/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) <u>this hospital</u> attended the deceased from 2/11 19 70 to 3/4 19 71 that (2) <u>we</u> last saw the deceased alive on 3/4 19 71 and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>We</u> (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Louis A. Shpritz MD | | 23B. DATE SIGNED 3/4/71 | |
| 23C. PHYSICIAN'S NAME (Type) Louis A. Shpritz, MD | | 23D. ADDRESS University Hosp. Balto., Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/1971 | |
| 24C. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery | | 24D. LOCATION (City, town, or county) (State) Westminster Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, MD | |
| 25C. FUNERAL DIRECTOR Thomas D. Fletcher | | 25D. ADDRESS 254 E. Main Street MD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | |
|---|--|--|
| <div style="display: flex; justify-content: space-between;"> 11-465 71 2404 BALTIMORE CITY HEALTH DEPARTMENT 71 2404 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | REG. NO. X |
| BIRTH NO. X | | 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> XXX 3 4 71 7:45PM M. </div> |
| 1. NAME OF DECEASED (Type or Print) MULHERN, FLORA A. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY WASHINGTON |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL 10 BALTO., MD. 21229 | | C. CITY OR TOWN BIG POOL D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER NONE |
| 8. DATE OF BIRTH 4 15 01 9. AGE (In years last birthday) 69 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRI. REG. NURSE | | 10B. KIND OF BUSINESS OR INDUSTRY RET. REG. NURSE |
| 11. BIRTHPLACE (State or foreign country) PENNA. | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME LOUIS MIZELL | | 14. MOTHER'S MAIDEN NAME ANNIE WATSON |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO | | 16. SOCIAL SECURITY NO. 214-34 0589 |
| 17. INFORMANT ST AGNES HOSP., BALTO., MD. | | ADDRESS |
| 18. I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-weight: bold; margin-top: 10px;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week. 2 years. |
| 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (this hospital) attended the deceased from 2/22 1971 to 3 4 1971 that (we) last saw the deceased alive on 3 4 1971 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (we) (did) (did not) view the body after death. | | |
| 23A. SIGNATURE Bishan. Elrahmy | | 23B. DATE SIGNED 03/05/71 |
| 23C. PHYSICIAN'S NAME (Type) XXXXXXXXXXXXXXXXXXXX DR. F. BRAHIMY | | 23D. ADDRESS ST AGNES HOSP., BALTO., MD. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/71 |
| 24C. NAME OF CEMETERY or CREMATORY Rose Hill Cemetery | | 24D. LOCATION (City, town, or county) (State) Clear Spring, Wash. Co. Md. |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR R. E. J. G. M. D. |
| 25C. FUNERAL DIRECTOR R. E. J. G. M. D. | | ADDRESS R. E. J. G. M. D. Clear Spring |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2405 |
|---|--|---|--|--|
| BIRTH NO. B-400 | | 71 2405 | | |
| 1. NAME OF DECEASED (Type or Print) GEORGE LEO BLEY SR. | | 2. DATE AND HOUR OF DEATH 3/9/71 1640 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Baltimore | | |
| 5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Ruxton D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD | | 11. BIRTHPLACE (State or foreign country) Towson Maryland | | |
| 10B. KIND OF BUSINESS OR INDUSTRY Bendix | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME John Hamilton Bley | | 14. MOTHER'S MAIDEN NAME Annie Laurie Erek | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI | | 16. SOCIAL SECURITY NO. 217-051156 | | |
| 17. INFORMANT Mrs. Mildred C. Bley | | ADDRESS 8415 Bellona Ave | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) gastro. ulcer gastro-intestinal hemorrhage | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: gastro. ulcer gastro-intestinal hemorrhage | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: Rotam Alghali | | |
| | | (C) _____ | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 2/28 3/6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GI Bleeding; Evisceration | | 20A. AUTOPSY? (Yes or No) Yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 02/13/71 19 71 to 03/09 19 71 that (I) (we) last saw the deceased alive on 03/09 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Edmar J. Crothers | | 23B. DATE SIGNED 3/9/71 | | 23C. PHYSICIAN'S NAME (Type) Edmar J. Crothers MD |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-71 | | 24C. NAME OF CEMETERY OR CREMATORY PARKWOOD |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | 25B. NAME OF REGISTRAR Edmar J. Crothers | | 25C. FUNERAL DIRECTOR DM. COOK-BROOKS TOWSON INC. |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2406 | |
|---|-----------------------------|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> W-514 71 2406 BIRTH NO. </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) HARRIET Elaine WIMBLEY | | | 2. DATE AND HOUR OF DEATH 3/9/71 1050 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 10 Gould Convalesarium | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 2744 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5704 Sefton Lane | | |
| 5. SEX female | 6. RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 12, 1899 | 9. AGE (In years last birthday) 71 Yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Penna. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME John Phillips | | |
| 14. MOTHER'S MAIDEN NAME ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - - - - - | | |
| 16. SOCIAL SECURITY NO. 123-05-4723 | | | 17. INFORMANT Leon Wimbley, Same as # 4 | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14R | |
| (A) IMMEDIATE CAUSE CEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF: | | | | Sudden | |
| (B) CEREBRAL ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: | | | | 14R | |
| (C) | | | | 14R | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). fracture of arm | | | | | |
| 19A. DATE OF OPERATION 2/4/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5704 Sefton Lane | |
| 21D. TIME OF INJURY (APPROX.) 2/4/71 | | 21F. HOW DID INJURY OCCUR? fell, getting out of bed | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/9/71 11/5 1970 to 3/9 1971 that (I) (we) last saw the deceased alive on 3/9/71 1971 and that (my) (our) opinion death occurred on the date 3/9/71 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Berger | | | | 23B. DATE SIGNED 3/9/71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Berger | | | | 23D. ADDRESS DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-11-71 | | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park | |
| 24D. LOCATION (City, town, or county) (State) Woodlawn, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1971 | | | |
| 25B. NAME OF REGISTRAR Robert E. Bailey, Jr. | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. | | | |
| 25D. ADDRESS 1050 York Rd. Towson Md. | | 2120 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2407 | |
|---|-------------------------|--|---|--|---|
| 11-460 71 2407 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Miller, Veronica</i> | | 2. DATE AND HOUR OF DEATH <i>3-9-71 3:15 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>2733</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hospital</i> | | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | E. STREET AND NUMBER <i>2201 Southern Ave</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1-10-60</i> | 9. AGE (In years last birthday) <i>11 yrs</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME <i>heroy Miller</i> | | 14. MOTHER'S MAIDEN NAME <i>Carolyn Johnson</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Helga Johnson 2201 Southern Ave</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH <i>Sudden</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiovascular arrest</i> (B) <i>Idiopathic myocardopathy</i> DUE TO, OR AS A CONSEQUENCE OF: <i> congestive failure</i> (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12-15 mos.</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>12/14/70</i> to <i>3/9/71</i> , that (1) (we) lost saw the deceased olive on <i>3/9/71</i> and that in (my) four opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>H. Stephen Williams, M.D.</i> DEGREE | | | | 23B. DATE SIGNED <i>3/9/71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>H. Stephen Williams, M.D.</i> DEGREE | | | | 23D. ADDRESS <i>The Johns Hopkins Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>3/12/71</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>mt. Auburn</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Balto; md</i> | | 24E. DATE REC'D BY HEALTH DEPT. | | | |
| 24F. NAME OF REGISTRAR <i>00</i> | | 24G. FUNERAL DIRECTOR <i>00</i> | | 24H. ADDRESS <i>1304 N. Central Ave</i> | |

CERTIFICATE OF DEATH

REG. NO. 71 2408

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Peay, Kattie Mae

2. DATE AND HOUR OF DEATH

3-7-71

1: 20 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1802 32nd Street 21218

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-16-59

9. AGE (In years
last birthday) 11

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert

14. MOTHER'S MAIDEN NAME

Skinner, Irma

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

BCH RECORDS:

ADDRESS
4940 Eastern Avenue

Baltimore, Md. 212224

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE Burn Wound Septic Shock
DUE TO, OR AS A CONSEQUENCE OF:(B) 35% Thermal Burn
DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

B: Internal Pneumonia

19A. DATE OF OPERATION

32/23/71

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Thermal Burns

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

1802-32nd St. (Home)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

9-06

21D. TIME
OF INJURY
(APPROX)(Month) (Day) (Year) (Hour)
1/24/71

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☒

21F. HOW DID INJURY OCCUR?

fireplace sparks
ignited clothing22. I certify that (1) (this hospital) attended the deceased from 1/25 1971 to 3/17 1971
that (1) (we) last saw the deceased alive on 3/17 1971 and that (1) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (we) (did) (the) view the body after death.

23A. SIGNATURE

Robert K. Fabian MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3/27/71

23C. PHYSICIAN'S
NAME (Type)

Robert K. Fabian MD

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/11/71

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem

24D. LOCATION

(City, town, or county)

A. A. County, Md

25A. DATE REC'D BY HEALTH DEPT.

MAR 11 1971

25B. NAME OF REGISTRAR

Robert K. Fabian MD

25C. FUNERAL DIRECTOR

Joseph J. Rock 1304 N. Central Ave

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

General Board
of the Navy

1890

1890

1890

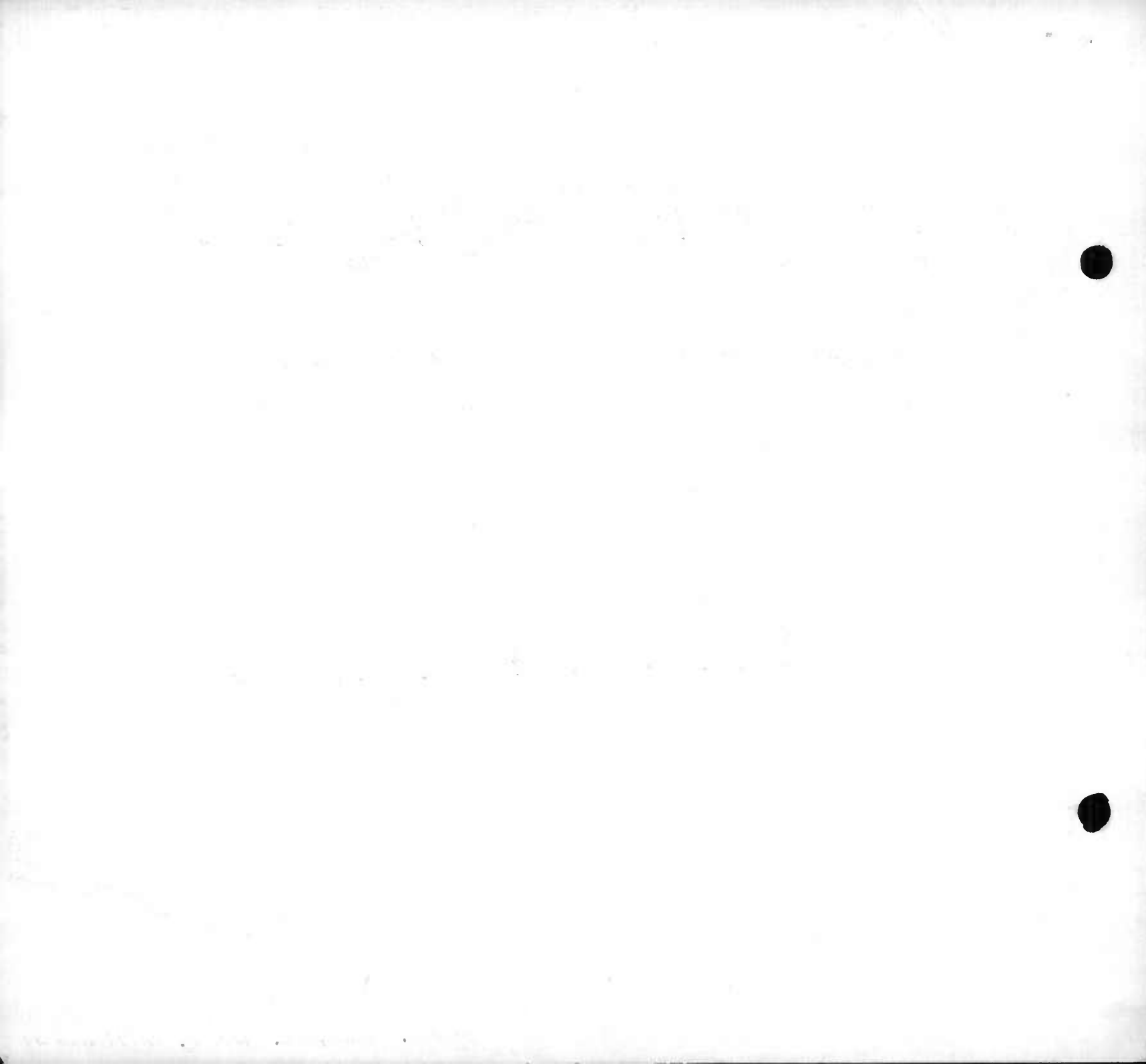
1890

1890

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | 71 2409 | REG. NO. |
|--|------------------|---|---|---|---|
| BIRTH NO. K-450 | | 71 2409 | | | |
| 1. NAME OF DECEASED (Type or Print) HELEN E. KALHOUN | | | 2. DATE AND HOUR OF DEATH 3/7/71 5:00 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME & HOSPITAL 100, N. BROADWAY, BALTIMORE | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3617 E. FAYETTE ST. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT 1, 1908 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) N. JERSEY | |
| 13. FATHER'S NAME FRANK POND | | | 14. MOTHER'S MAIDEN NAME SARAH GULICK | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-01-0938 | | 17. INFORMANT DR. S. SINGH ADDRESS CHURCH HOME & HOSPITAL | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intractable Congestive Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last ASVD & possible Laenne's cirrhosis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH undetermined years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/13 19 71 to 3/7 19 71 that (I) (we) last saw the deceased alive on 3/7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. Maniago | | | | 23B. DATE SIGNED 3/7/71 | |
| 23C. PHYSICIAN'S NAME (Type) WILMA B. MANIAGO | | | | 23D. ADDRESS CHURCH HOME & HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/71 | | 24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | | |
| 25B. NAME OF REGISTRAR John A. Moran, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 3000 E. Baltimore St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2410 | |
|--|-------------------------|---|-------------------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) Phalen, Blanche H | | 2. DATE AND HOUR OF DEATH March 7 1971 17h, 20 minutes | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 3625 OLD YORK ROAD | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-28-83 | 9. AGE (In years last birthday) 87 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Delicatessen | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICAN | | 13. FATHER'S NAME JAMES W. WOOD | | | |
| 14. MOTHER'S MAIDEN NAME REBECCA ELLICKSON | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 212-30-7716 | | 17. INFORMANT ADDRESS CHART | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CEREBROVASCULAR ACCIDENT | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 7 1971 to MARCH 7 1971 that (I) (we) last saw the deceased alive on MARCH 7 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Julio Bertorini MD | | | | 23B. DATE SIGNED March 7 1971 | |
| 23C. PHYSICIAN'S NAME (Type) JULIO BERTORINI MD | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/71 | | 24C. NAME of CEMETERY or CREMATORY Salem Church Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Upper Falls, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | | |
| 25B. NAME OF REGISTRAR John A. Morgan, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 3000 E. Baltimore St. | | | |



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Vincent Mulligan

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

92 Central District Police Station

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

March 7, 1971

4:50 A.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Pa.

K-35

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Philadelphia

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12/23/1921

10. AGE (In years
last birthday)

49

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

613 E. Cheltenham Ave.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Mulligan

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Delia

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

17. SOCIAL
SECURITY NO.

201-12-1613

18. INFORMANT

ADDRESS Phil., Pa.

Joseph Mulligan-613 E. Cheltenham Ave.

19.

303.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Acute pneumonitis

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Acute ethylism

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT ☐
WORKNOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 7, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/11/71

24C. NAME of CEMETERY or CREMATORY

Holy Sepulchre Cemetery-Cheltenham-Montgomery City

24D. LOCATION (City, town, or county) (State)

John of. Moran, Address

5000 E. Baltimore St.

Baltimore, Md. 21224

25A. DATE REC'D BY HEALTH DEPT.

MAR 11 1971

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

4-7-71 M.H.

4-7-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

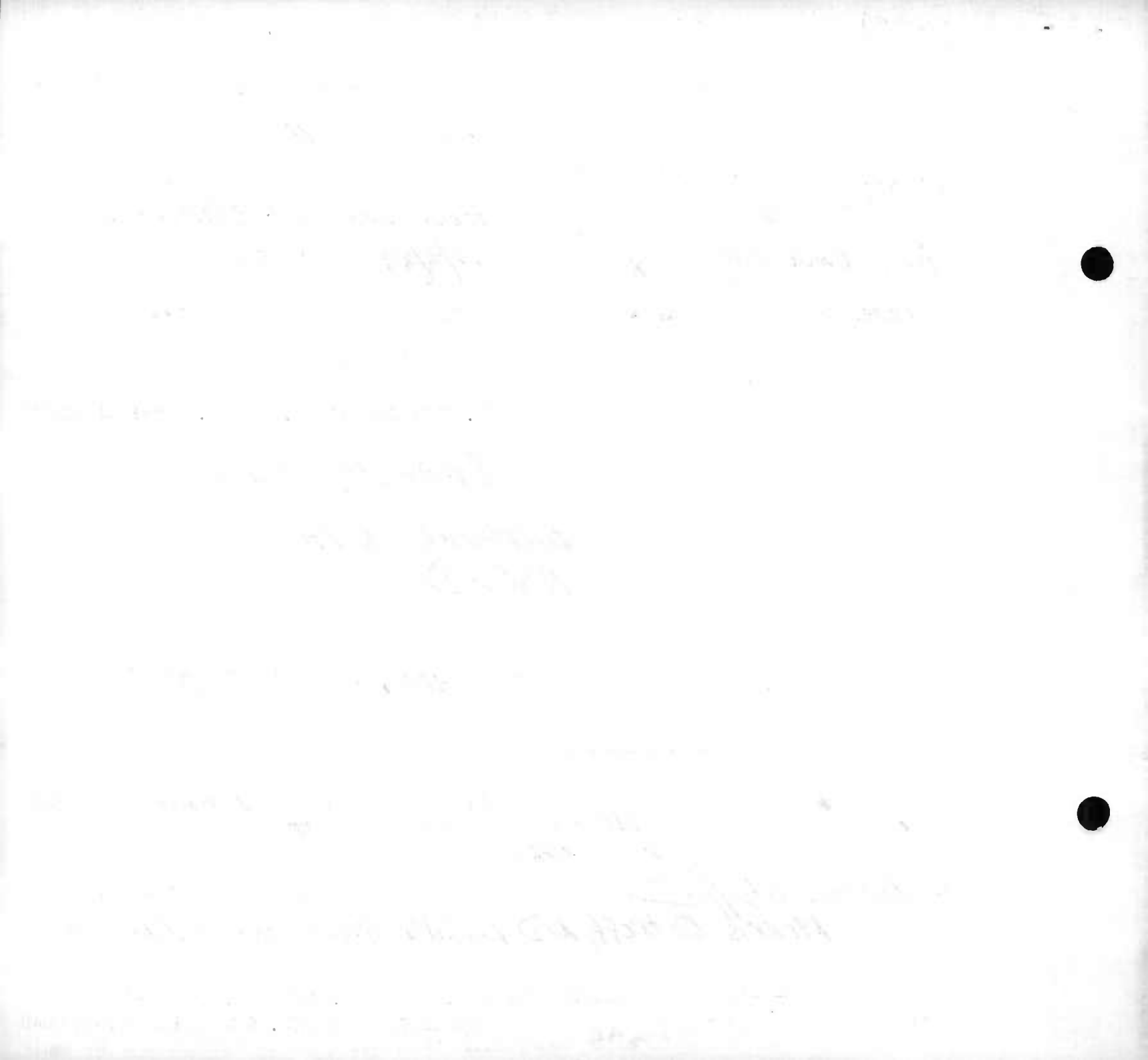
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 2412 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH X REG. NO. 71 2412 | |
|--|------------------|---|--|---|---|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>WILLIAM G. ULRICH, Sr.</u> | | | | 2. DATE AND HOUR OF DEATH <u>Mar. 7, 1971</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Md. GEN HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>38 Seaford Ave Balto. Md 21221</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/2/01</u> | 9. AGE (in years last birthday) <u>69</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Martins</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>John Ulrich</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>Emma Rogers</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | |
| 16. SOCIAL SECURITY NO. <u>211-03-4068</u> | | | 17. INFORMANT <u>William G. Ulrich, Jr. 18 Fullerton Heights</u> | | | | |
| 18. <u>344.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Aspiration Pneumonia</u> <u>Pneumothorax</u> (B) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Urinary Tract Infection</u> (C) _____ | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> 19 <u>71</u> to <u>3/7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/7</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Layman B. Elmer, M.D.</u> | | | | 23B. DATE SIGNED <u>3/7/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Layman B. Elmer, M.D.</u> | |
| 23D. ADDRESS <u>Dessahn Funeral Home 7101 Belair Rd. 21236</u> | | | | 23E. DEGREE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-10-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Holly Hill Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Bird River Rd. Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 11 1971</u> | | 25B. NAME OF REGISTRAR <u>John G. Smith, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Dessahn Funeral Home</u> | | 25D. ADDRESS <u>7101 Belair Rd. 21236</u> | |



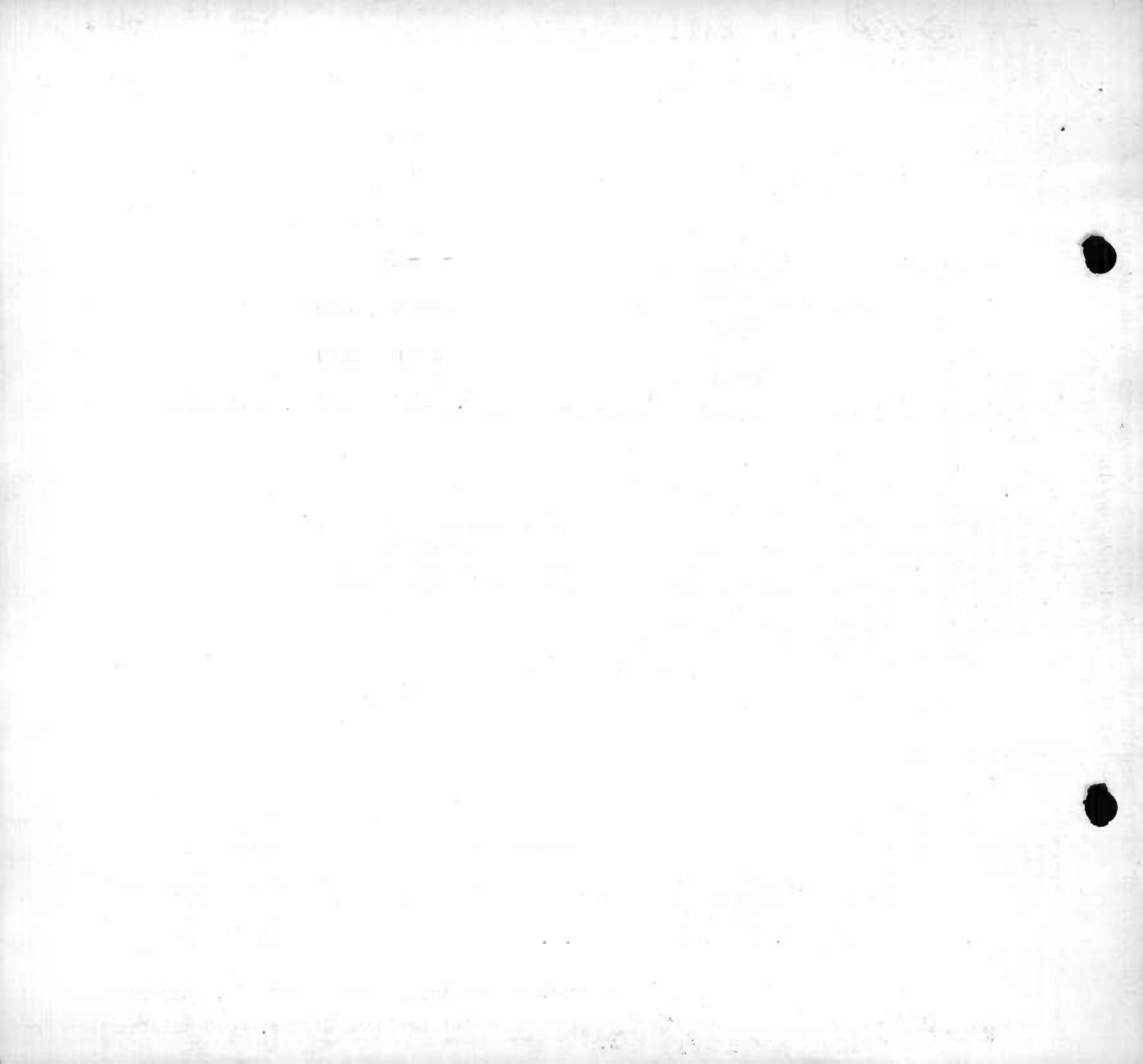
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| S-220 | | 71 2413 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2413 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Anne Sykes</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>6 March 1971 8:15 P.M.</i> | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Belt</i> | | | | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Levinthal Hebrew Home & Infirmary</i> | | | |
| C. CITY OR TOWN <i>Balto</i> | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER <i>2808 QUANTICO AVENUE</i> | | | | F. ZIP CODE <i>21216</i> | | | |
| 5. SEX <i>Female</i> | | 6. RACE <i>WHITE</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>XXXXXX</i> | |
| 9. AGE (in years last birthday) <i>87</i> | | If Under 1 Yr. Months: Days: Hours: Min. | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>LITHUANIA</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 13. FATHER'S NAME <i>HASKEL SAPERSTEIN</i> | | | | 14. MOTHER'S MAIDEN NAME <i>NAOMI ?</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | | 16. SOCIAL SECURITY NO. <i>NO</i> | | 17. INFORMANT <i>MRS. BEATRICE SNYDER, 3015 W. GARRISON AVENUE</i> | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <i>GRAN Neg Sepsis</i> <i>Bilateral CVA</i> <i>ASLD</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from <i>25 Oct 1963</i> to <i>6 March 1971</i> that (we) last saw the deceased alive on <i>6 March 1971</i> and that (my) (our) applan death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Morris Ostroff</i> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>6 March 71</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>MORRIS OSTROFF, MD</i> | | | | 23D. ADDRESS <i>Levinthal Hebrew Home + Infirmary</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>3-8-71</i> | | 24C. NAME of CEMETERY or CREMATORY <i>OHR KNESSETH ISRAEL ANSHE SEARD</i> | | 24D. LOCATION (City, town, or county) (State) <i>ROSEDALE, MARYLAND</i> | |
| 25A. RECEIVED BY HEALTH DEPT. <i>MAR 11 1971</i> | | 25B. NAME OF REGISTRAR <i>E. E. E. E. E.</i> | | 25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD</i> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-160 71 2414 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2414 | |
|--|-------------------------|---|-------------------------------------|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) MARY SHAPIRO | | 2. DATE AND HOUR OF DEATH 3/6/71 10³⁰ A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2788 | | C. CITY OR TOWN BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 5311 NELSON AVE | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 09-16-15 | 9. AGE (In years lost birthday) 55 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Hanover, Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME GEORGE COPENHEAVER | | 14. MOTHER'S MAIDEN NAME MINNIE BOLLINGER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-50-3679 | | 17. INFORMANT Mr. Melvin Shapiro, 5311 Nelson Avenue 21215 | |
| 18. 398X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Shock - ? Septic ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Emboli (B) DUE TO, OR AS A CONSEQUENCE OF: Rheumatic Heart Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 2-15-1971 to 3-6-1971 , that (I) (we) last saw the deceased alive on 3-6-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Trexler M. Topping MD | | 23B. DATE SIGNED 3/6/71 | | 23C. PHYSICIAN'S NAME (Type) TREXLER M. TOPPING M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/7/1971 | | 24C. NAME OF CEMETERY or CREMATORY Ohr Knesseth Israel Anne Sfar | |
| 24D. LOCATION (City, town, or county) (State) Rosedale, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR Sei Levinson | |
| 25C. FUNERAL DIRECTOR Bros. 6010 Reisterstown Road | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of ar./ nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2415</u> | |
|---|--|---|---|--|---|
| W-536 71 2415 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED (Type or Print) WINTER, Arthur M. | | | 2. DATE AND HOUR OF DEATH 3/5/71 7:45am | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2720 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | E. STREET AND NUMBER 5906 Park Heights Ave. Apt. 305 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/5/15 | 9. AGE (In years lost birthday) 55 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT | | 10B. KIND OF BUSINESS OR INDUSTRY RETAIL | 11. BIRTHPLACE (State or foreign country) BROOKLYN, NEW YORK | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Jacob Winter | | | 14. MOTHER'S MAIDEN NAME Helen Hauser | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY | | 16. SOCIAL SECURITY NO. 335-09-4222 | 17. INFORMANT ADDRESS MRS. ELSIE WINTER, 5906 PARK HGHTS. AVE., APT. 305 | | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardio-Respiratory failure A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: B. DUE TO, OR AS A CONSEQUENCE OF: C. Hypertension II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/21 19 71 to 3 15 19 71 , that (I) (we) last saw the deceased alive on 7:45am 3/5 (Fri) 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Paul Whelan M.D. BCh BAO | | | 23B. DATE SIGNED 3/5/71 | | 23C. PHYSICIAN'S NAME (Type) PAUL WHELAN M.D. BCh BAO |
| 23D. ADDRESS Johns Hopkins Hosp. Baltimore | | | 23E. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-7-71 | 24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND |
| 25A. NAME OF REGISTRAR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | 25B. NAME OF REGISTRAR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

G-600

71 2416

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2416

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Cynthia Gray

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month
3Day
7Year
71Hour
3:42 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40

St. Agnes Hospital

3. DATE
PRONOUNCED DEADMonth
3Day
7Year
71Hour
3:42 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
Md.

B. COUNTY

D.C.W. 5200

C. CITY OR TOWN

Glen Burnie

D. INSIDE CITY LIMITS?

YES ☐NO ☐

6. SEX

female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

December 29 1953

10. AGE (In years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

7990 Crainmont Dr. 21061

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Omer E. Gray

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

School

15. MOTHER'S MAIDEN NAME

Roslie Enzenga

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

Omer E. Gray 7990 Crainmont Dr. 21061

ADDRESS

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Multiple injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Park

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Patapsco State Park 5200

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 3 7 71 3:00p.m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject struck on head by falling tree.

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/8/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

March 10, 1970 New Cathedral Cemetery

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

Balto. Md. 21229

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 11 1971

25B. NAME OF REGISTRAR

Russell S. Fisher, M.D.

25C. FUNERAL DIRECTOR

Mc Cully Funeral Home 237 Patapsco Ave

ADDRESS

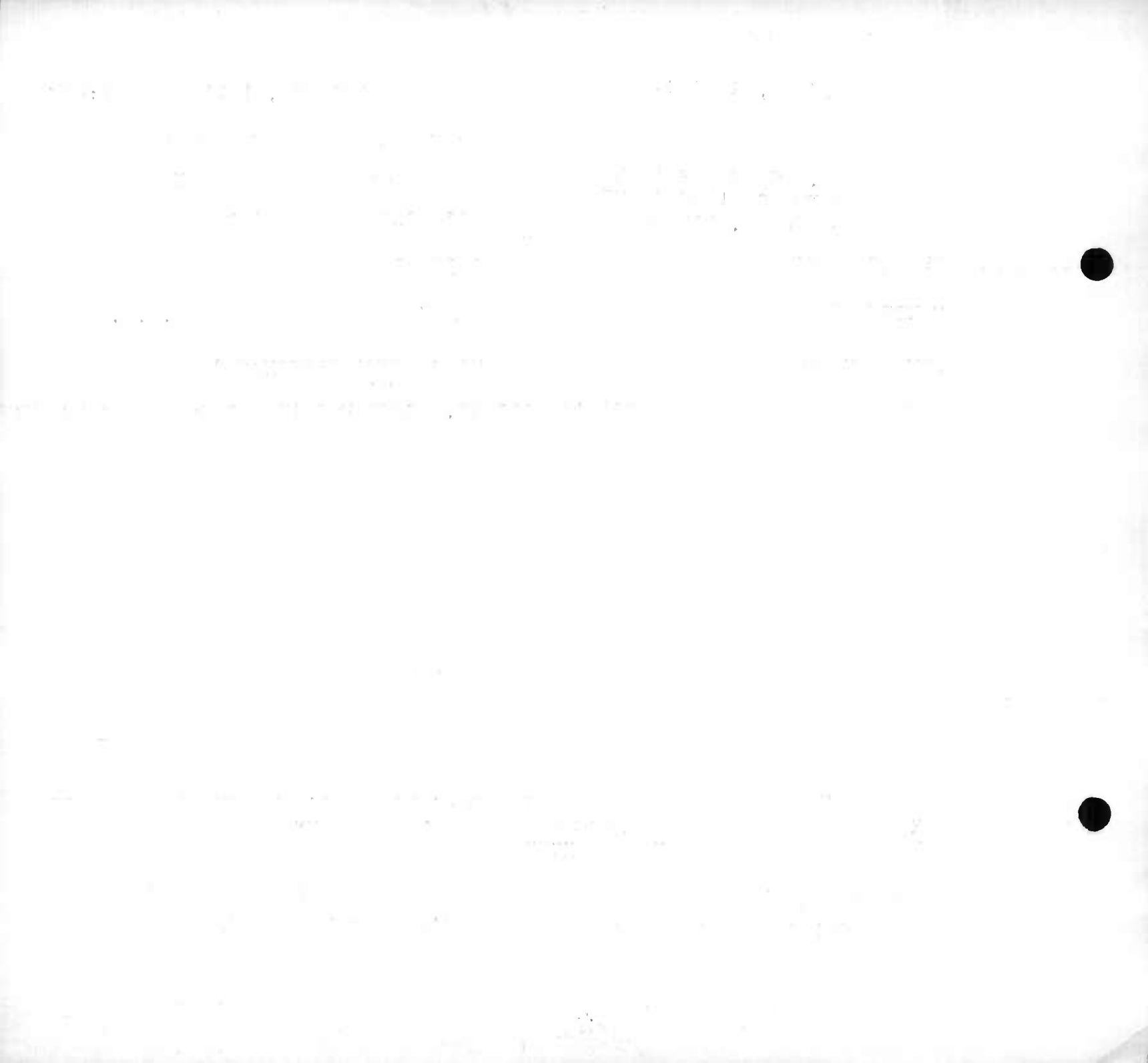
Q15 15

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. <u>71 2417</u> | |
| B-550 71 2417 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) BEYNON, GERTRUDE | | 2. DATE AND HOUR OF DEATH MARCH 08, 1971 3:20P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVE BALTO MD. 21229 | | A. STATE MARYLAND B. COUNTY ANNE ARUNDEL 5200 | |
| | | C. CITY OR TOWN PASADENA D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 119 CLUB ROAD 21122 | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 01 30 83 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK | | 10B. KIND OF BUSINESS OR INDUSTRY -- | 9. AGE (In years last birthday) 88 |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN BEYNON | | 14. MOTHER'S MAIDEN NAME MARGARETHE (FITCHNER) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 214 46 9123 | |
| | | 17. INFORMANT AVE ADDRESS ST. AGNES HOSPITAL CATON AVE & WILKENS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute MI, Pulm. infection | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe ASCVD. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II | | | |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 20 19 71 to MARCH 08 19 71 that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on MARCH 08 19 71 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Ching Hui Tsai M.D.</i> | | 23B. DATE SIGNED 3 9 71 | |
| 23C. PHYSICIAN'S NAME (Type) CHING H TSAI MD | | 23D. ADDRESS WILKENS & CATON BALTO MD 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/12/71 | 24C. NAME of CEMETERY or CREMATORY Dulaney Valley Memorial Gardens | 24D. LOCATION (City, town, or county) (State) Cockeysville, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | 25B. NAME OF REGISTRAR 24.01.3.62.42 | 25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Road 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

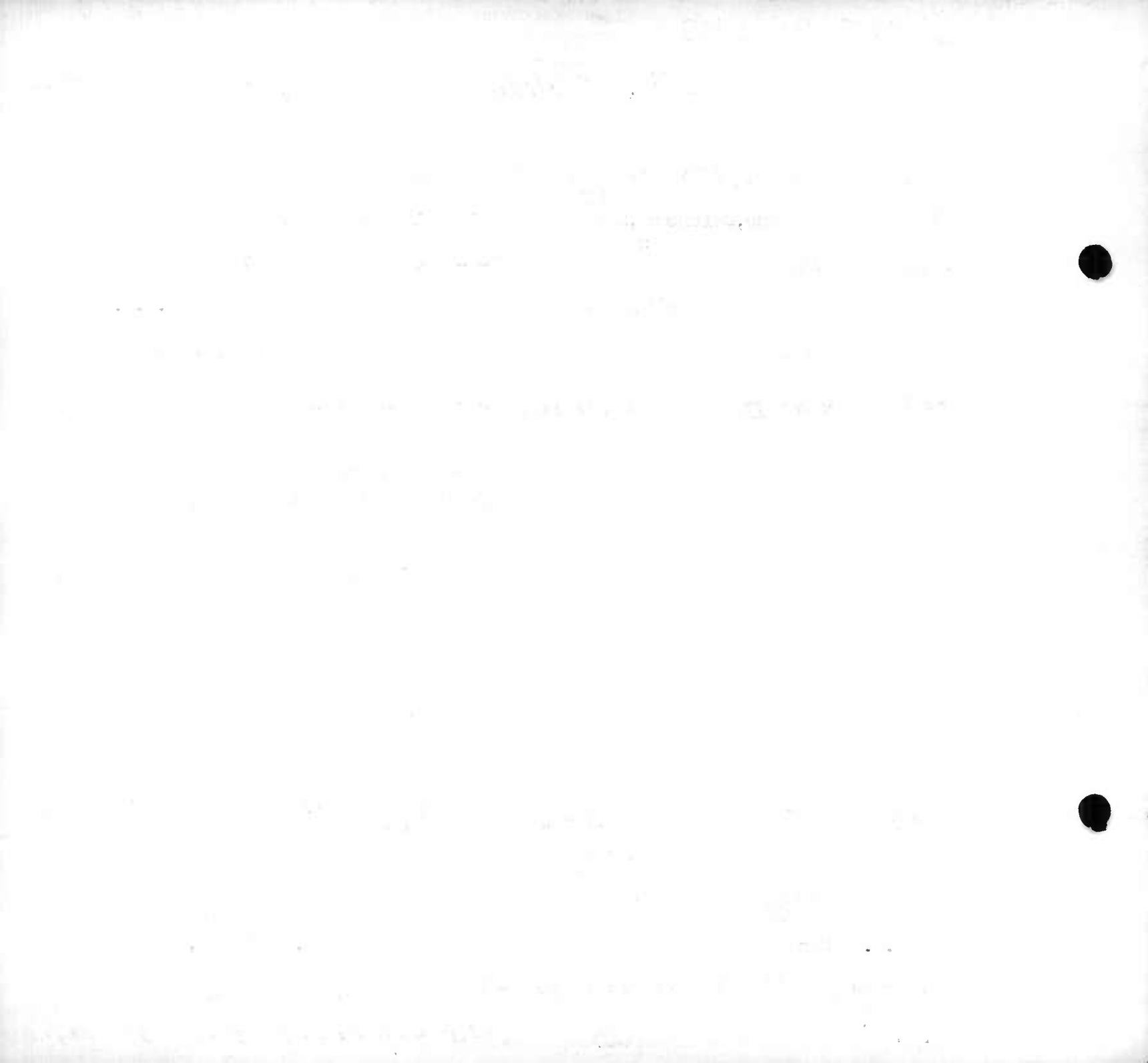
| BIRTH NO. <u>G-653 71 2418</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. <u>71 2418</u> | |
|--|------------------|---|--|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>ANNA E. GRANT</u> | | | | 2. DATE AND HOUR OF DEATH <u>3/7/71 1040 PM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>30. BALTO. GEN</u> | | | | A. STATE <u>MD</u> | | B. COUNTY <u>BALTO</u> | |
| | | | | C. CITY OR TOWN <u>ESSEX</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>325 Savannah Road</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9/22/98</u> | 9. AGE (in years last birthday) <u>72</u> | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>KANSAS</u> | |
| 13. FATHER'S NAME <u>Henry Shane</u> | | | | 14. MOTHER'S MAIDEN NAME <u>LENA ? COTTON</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u> | | | | 16. SOCIAL SECURITY NO. <u>220-03-9131</u> | | 17. INFORMANT <u>DAVID GRANT</u> ADDRESS <u>ABOVE</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CANCER OF THE UTERUS - METASTASIS - THE LUNGS</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> 19 <u>71</u> to <u>3/7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/7</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>3/7/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ESPINOZA</u> | | | | 23D. ADDRESS <u>3001 S. Danvers St</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3/11/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>SACRED HEART</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTO. MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 11 1971</u> | | 25B. NAME OF REGISTRAR <u>BRUCE J. [Signature]</u> | | 25C. FUNERAL DIRECTOR <u>J. J. CONNELLY</u> | | ADDRESS <u>SONS 300 MACE</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>C-365 71 2419</u> | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. <u>71 2419</u> | |
|--|-------------------------|---|-------------------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) <u>RAYMOND J. CITRANO</u> | | 2. DATE AND HOUR OF DEATH <u>3/9/71 5:15 AM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2605</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> 21224 | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 4940 Eastern Avenue, Baltimore, Maryland | | E. STREET AND NUMBER <u>311 Folcroft Street 21224</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-8-1924</u> | 9. AGE (in years last birthday) <u>47</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Charles</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary SAIA</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u> | | | |
| 16. SOCIAL SECURITY NO. <u>219-18-2671</u> | | 17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue 21224</u> | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA OF LUNG WITH METASTASES</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~6 mos</u> | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: <u>PNEUMONIA</u> | | (C) <u>COPD</u> | | <u>~2 mos</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-24</u> 19 <u>71</u> to <u>3-9</u> 19 <u>71</u> that (II) (we) last saw the deceased alive on <u>3-8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>R.K. Maza MD</u> | | 23B. DATE SIGNED <u>3/9/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>R.K. Maza</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3/12/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>SACRED HEART</u> | |
| 24D. LOCATION <u>BALTO. MD</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 11 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>Blaise J. Blaise, Jr.</u> | | 25C. FUNERAL DIRECTOR <u>J. J. FORD</u> | | 25D. ADDRESS <u>300 MACE</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2420</u> | |
|---|------------------|---|--|---|---|
| <div style="display: flex; justify-content: space-between;"> <u>H-431</u> <u>71 2420</u> </div> | | | | <div style="display: flex; justify-content: space-between;"> <u>3/7/71</u> <u>12:40 A.M.</u> </div> | |
| 1. NAME OF DECEASED (Type or Print) <u>MARY HILDE BRANDT</u> | | | | 2. DATE AND HOUR OF DEATH | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 CHURCH HOME HOSPITAL</u> | | | | A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u> | |
| | | | | C. CITY OR TOWN <u>BALTO ESSEX</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>218 RIVERSIDE RD.</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/31/03</u> | 9. AGE (In years last birthday) <u>67</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | |
| 13. FATHER'S NAME <u>THOMAS BEALL</u> | | | | 14. MOTHER'S MAIDEN NAME <u>LIZZIE RODRICK</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>JOHN HILDEBRANDT ABOVE</u> | |
| 18. CAUSE OF DEATH | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><u>25071</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p><u>Cardiac Arrest + fibrillation</u></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p><u>ASCVD, Chronic AF, uremia</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p><u>Diabetes Mellitus</u></p> <p>(C)</p> </div> <div style="width: 5%; text-align: center;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>minutes</u></p> </div> </div> | | | | | |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> 19 <u>71</u> to <u>3/7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/7/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Wilma B. Maniago</u> M.D. DEGREE | | | | 23B. DATE SIGNED <u>3-7-71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>WILMA B. MANIAGO</u> DEGREE | | | | 23D. ADDRESS <u>CHURCH HOME & HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3/10/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u> | |
| 24D. LOCATION <u>BALTO. MD.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 11 1971</u> | | 25B. NAME OF REGISTRAR <u>Rebecca Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Church Home 300 Mace Ave</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

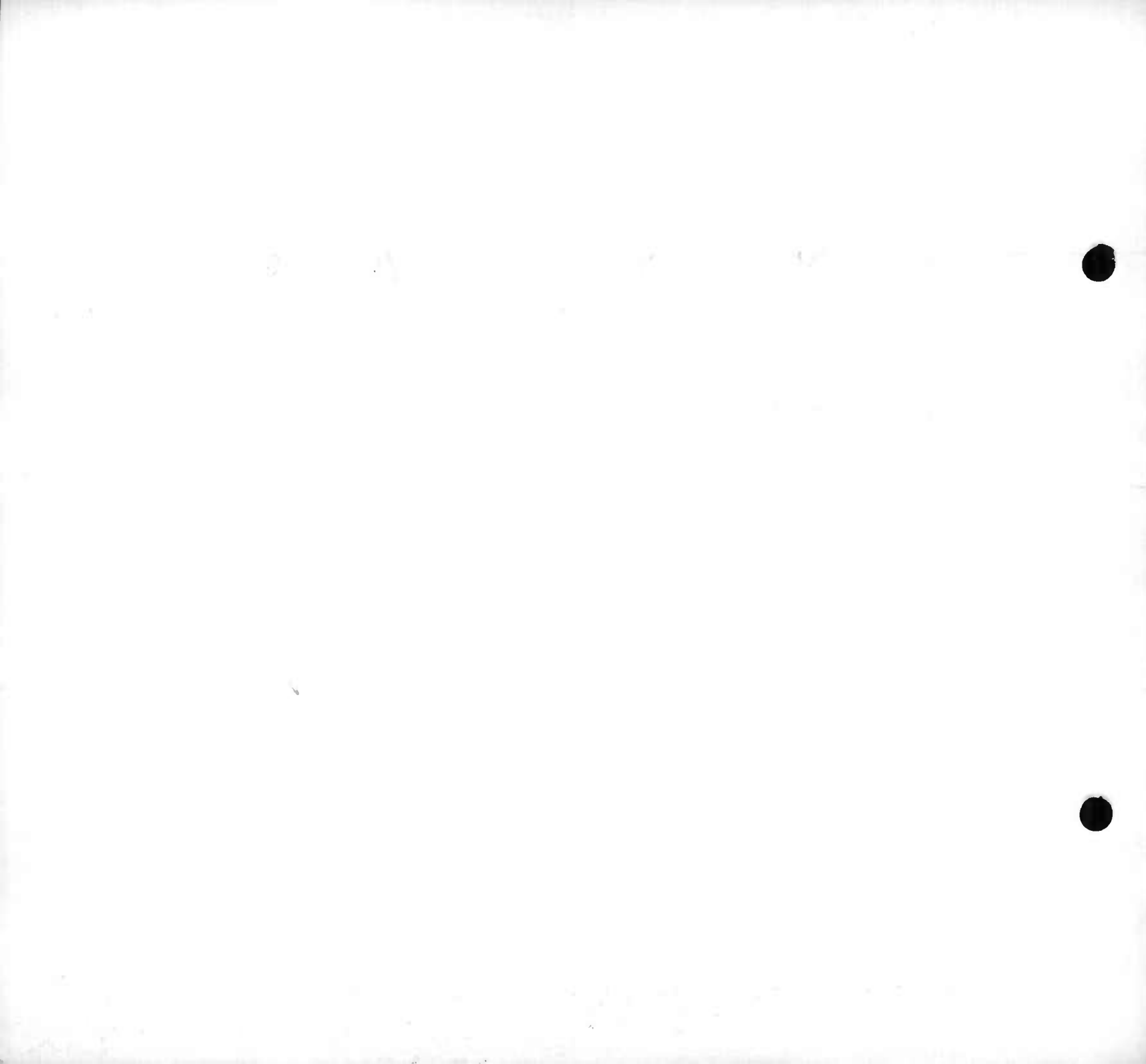
| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 71 2481 | |
|--|---------|--|------------------|--|---------------------------------|---|-------|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| ANTONIO DI BATTISTA | | 8 MARCH 1971 1:20 P. M. | | UNIV. of Md. Hosp. | | A. STATE Md. B. COUNTY BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 3222 S. GREENE ST. | | BALTO. MD 21201 | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | 351 NICHOLSON ROAD | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Yr. If Under 24 Hrs. | | |
| M | W | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 1/17/01 | 70 | Months | Days | Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| RET-CONST. WORKER | | | | ITALY | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| IGUROSIO DIBATTISTA | | | | DOMINICA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | NONE | | CHART FACE SHEET | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE | | | | 3 min | |
| ANTECEDENT CAUSES | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | and Cardiac Arrest | | | | 10 days | |
| | | (B) Pneumonitis | | | | 1 yr | |
| | | (C) CANCER of the LUNG | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | NONE | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 11/20/70 | | BIOPSY NODE CALUS | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| No | | NONE | | No | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| NONE | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | NONE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 11, 1970 to 8 March, 1971 that (I) (we) last saw the deceased alive on 8 March 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Francis Bartek MD | | | | 8 March 71 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| FRANCIS BARTEK MD | | | | UNIV. of Md. Hosp.; BALTO. MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 3/11/71 | | GARDENS OF FAITH | | BALTO. MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| MAR 11 1971 | | John A. Connelly | | J. A. CONNELLY SONS | | 300 N. W. 30th St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2422</u> |
|--|-------------------------|---|---------------------------------|--|
| BIRTH NO. <u>B-655</u> | | 71 2422 | | |
| 1. NAME OF DECEASED (Type or Print) <u>BERMAN YETTA</u> | | 2. DATE AND HOUR OF DEATH <u>3-8-71</u> <u>2:30</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital of Baltimore</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>2730</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER <u>6314 Breuninger Ave</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-18-90</u> | 9. AGE (in years last birthday) <u>80</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> |
| 13. FATHER'S NAME <u>Shaya Chazin</u> | | 14. MOTHER'S MAIDEN NAME <u>Levin</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Betty Ross</u> ADDRESS <u>6314 Breuninger Ave</u> |
| 18. <u>71231</u> | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE - <u>Coronary Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Pneumonia; Renal insufficiency</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (this hospital) attended the deceased from <u>2-19</u> 19 <u>71</u> to <u>3-8</u> 19 <u>71</u> that (we) last saw the deceased alive on <u>3-8</u> 19 <u>71</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Edoardo S. Victoria MD</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>3-8-71</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>Edoardo S. Victoria</u> | | 23D. ADDRESS <u>Sinai Hospital, Baltimore</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>3/9/71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Har Zion Tephel B'nai B'rith</u> | | 24D. LOCATION (City, town, or county) (State) <u>Md</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 11 1971</u> | | 25B. NAME OF REGISTRAR <u>Abel E. Cohen, R.D.</u> | | 25C. FUNERAL DIRECTOR <u>Sylvan Lewis & Son</u> ADDRESS <u>9610 Reisterstown Rd</u> |



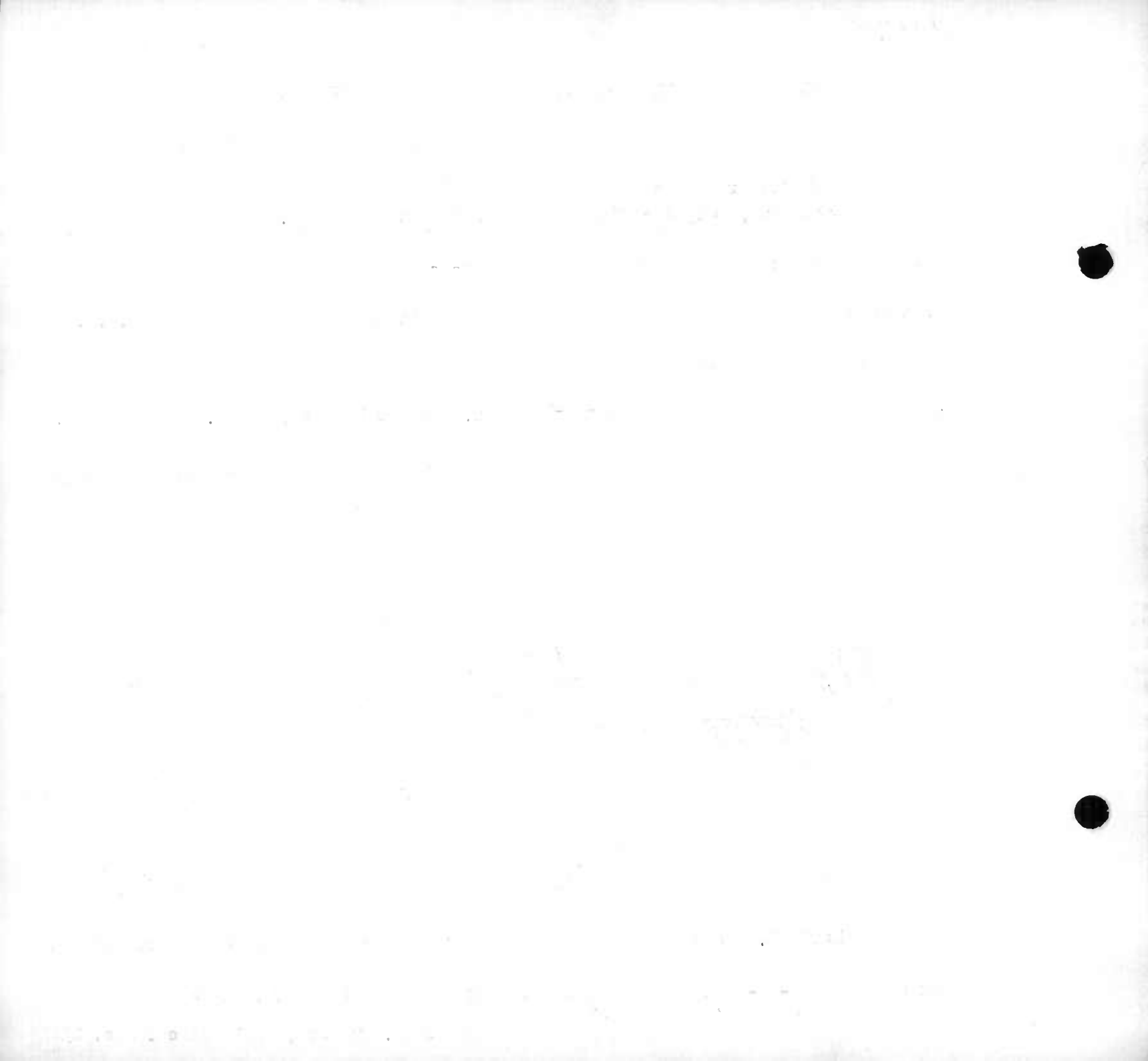
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2423</u> | |
|--|-------------------------|--|-------------------------------------|---|---|
| BIRTH NO. <u>B-625 71 2423</u> | | 1. NAME OF DECEASED (Type or Print) <u>BROGUNIER, MARY ELIZABETH</u> | | 2. DATE AND HOUR OF DEATH <u>MARCH 7, 1971</u> <u>10:05 A.</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2834</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSPITAL</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>4731 DUNKIRK AVENUE</u> | | <u>21229</u> | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>05/27/06</u> | 9. AGE (In years last birthday) <u>64</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Tommy Tucker Store</u> | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>() STONE</u> | | 14. MOTHER'S MAIDEN NAME <u>MARIE (A.)</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>820 02 8357</u> | | 17. INFORMANT <u>Mr. Wilbur A. Brogunier, 4731 Dunkirk Ave.</u> | |
| | | | | ADDRESS <u>ST. AGNES RECORDS-BALTO. MD 21229</u> | |
| 18. <u>431.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>massive intracerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>MARCH 1, 1971</u> to <u>MARCH 7, 1971</u> that <u>XX</u> (we) last saw the deceased alive on <u>MARCH 7, 1971</u> and that <u>XX</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (We) (did) <u>XX</u> view the body after death. | | | | | |
| 23A. SIGNATURE <u>Ching-Hui Tsai, M.D.</u> | | 23B. PHYSICIAN'S NAME (Type) <u>CHING-HUI TSAI, M.D.</u> | | 23C. DATE SIGNED <u>3/7/71</u> | |
| 23D. ADDRESS <u>St Agnes Hosp.</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-10-1971</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 11 1971</u> | | 25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u> | | 25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



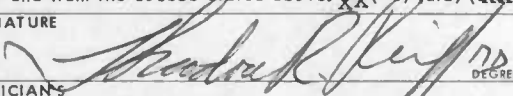
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

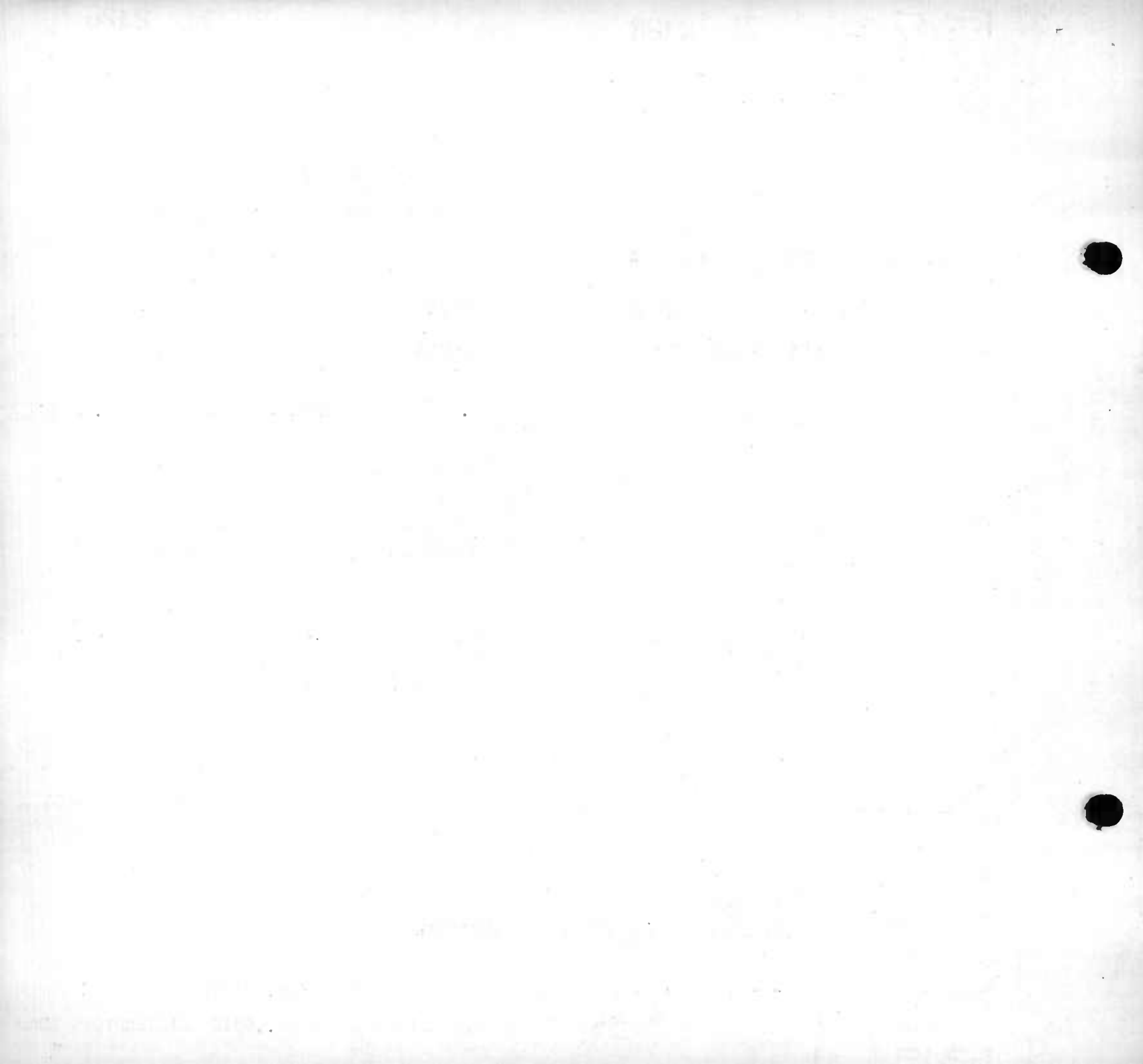
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2425</u> | |
|--|-------------------------|---|---|---|---|
| CERTIFICATE OF DEATH | | | | | |
| B-200 <u>71 2425</u> BIRTH NO. <u>70-18108</u> | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>PAMELA BASS</u> | | 2. DATE AND HOUR OF DEATH <u>2/15/71</u> <u>11:00 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 UNIVERSITY HOSPITAL</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1303</u> | | | |
| | | C. CITY OR TOWN <u>BALTO.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>2300 EUTAW PL.</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10/6/70</u> | 9. AGE (In years last birthday) <u>4</u> <u>9</u> Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>OSCAR BASS</u> | | | 14. MOTHER'S MAIDEN NAME <u>MARY WILKINS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT — ADDRESS — | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>REYES SYNDROME</u> <u>→ HEPATIC ENCEPHALOPATHY</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> — | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <u>2/12</u> 19 <u>70</u> to <u>2/15</u> 19 <u>71</u> that he (we) last saw the deceased alive on <u>2/15</u> 19 <u>71</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Dwight N. Fortier MD.</u> | | | | 23B. DATE SIGNED <u>2/15/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DWIGHT N. FORTIER MD.</u> | | | | 23D. ADDRESS <u>UNIV. HOSP. BALTO., MD.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2/20/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cemetery Baltimore</u> | |
| 24D. LOCATION (City, town, or county) <u>MD.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 11 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD.</u> | | 25C. FUNERAL DIRECTOR <u>2300 Eutaw Pl. Balt. Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

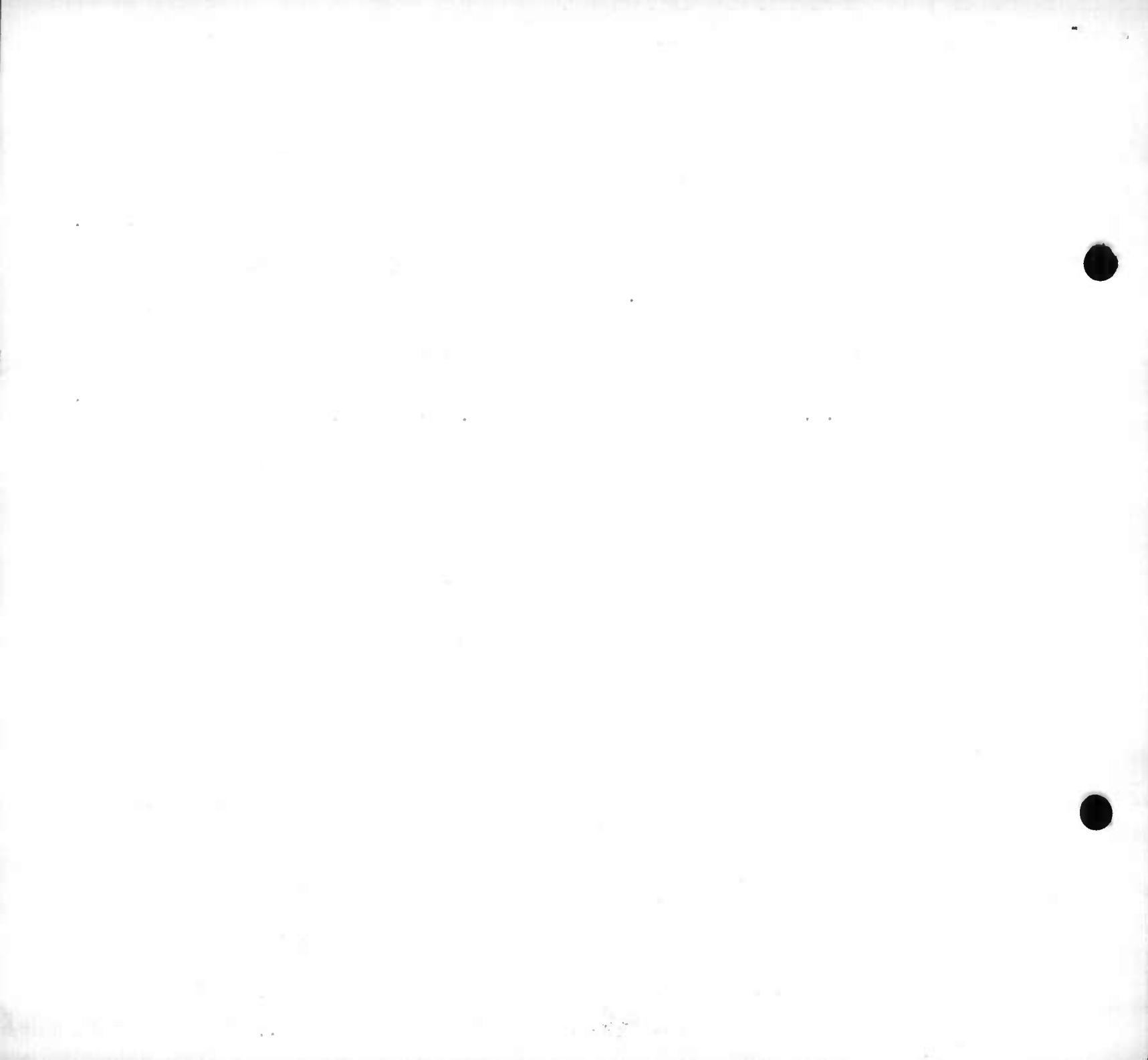
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | REG. NO. 71 2436 | |
|---|--|--|--|--|--|---|--|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) | | SARAH KRONGARD | | 2. DATE AND HOUR OF DEATH 3-8-1971 | | 7:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 91 Levindale | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2730 5. CITY OR TOWN BALTIMORE 6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER 3501 OLYMPIA AVENUE #21215 | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9. AGE (In years last birthday) 92 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) POLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME RAPHAEL HARRIS FORSHLAGER | | | |
| 14. MOTHER'S MAIDEN NAME CHAVA ? | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT MR. HARRY KRONGARD, 3501 OLYMPIA AVE. #21215 | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE <u>Probable Penetrating Peptic Ulcer</u> days DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Arteriosclerotic Heart Disease</u> months | | | | | | | |
| MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no (If in Baltimore City, give exact location) 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>10-24</u> 1969 to <u>3-8</u> 1971 , that (1) (we) last saw the deceased alive on <u>3-8</u> 1971 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) Theodore R. Reiff, MD | | | | | | 23B. DATE SIGNED 3-8-1971 | |
| 23D. ADDRESS LEVINDALE | | | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | |
| 24B. DATE 3-9-71 | | 24C. NAME OF CEMETERY or CREMATORY SHOMREI HADATH | | 24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR E. G. Gabley | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |



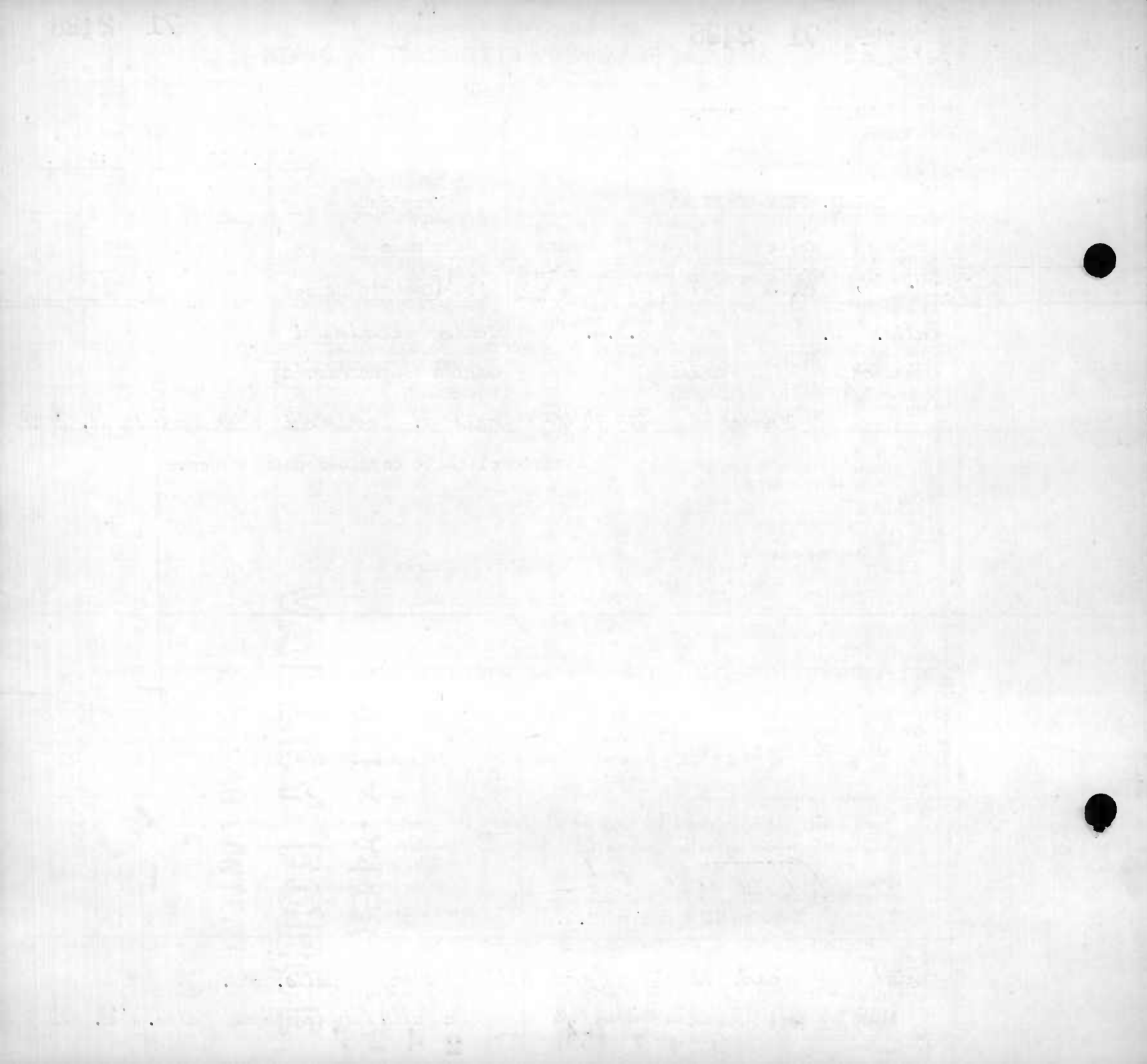
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2487</u> | |
|---|----------------------|--|--------------------------------------|---|--|
| L-150 71 2487 | | | | | |
| BIRTH NO. <u>1</u> | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>NATHAN LEVIN</u> | | 2. DATE AND HOUR OF DEATH <u>3/05/71</u> <u>12.02 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u> <u>48</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7939 DUNHILL VILLAGE CI., APT. 203</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/08/1897</u> | 9. AGE (In years last birthday) <u>73</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | |
| 13. FATHER'S NAME <u>JOSEPH LEVIN</u> | | 14. MOTHER'S MAIDEN NAME <u>ETTA ?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W. I</u> | | 16. SOCIAL SECURITY NO. <u>218-28-0862</u> | | 17. INFORMANT ADDRESS <u>APT. 203</u> <u>MRS. RIVA LEVIN, 7938 DUNHILL VILLAGE CIRCLE</u> | |
| 18. <u>200.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>DIABETES MELLITUS</u> <u>MASSIVE ANTERIOR WALL INFARCTION</u> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Posterior Wall Infarction & Pulmo</u> <u>nary edema.</u> (B) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>DIABETES MELLITUS</u> (C) <u>MASSIVE ANTERIOR WALL INFARCTION</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>25 years</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/3/71</u> 19 to <u>3/5/71</u> 19 that (I) (we) last saw the deceased alive on <u>3/5/71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>V. R. Felipa M.D.</u> | | 23B. DATE SIGNED <u>3/5/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>VICTOR R. FELIPA</u> | |
| 23D. ADDRESS <u>MARYLAND GENERAL HOSPITAL</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | |
| 24B. DATE <u>3-7-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>ANSHE EMUNAH</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 11 1971</u> | | 25B. NAME OF REGISTRAR <u>Rebecca J. B. ...</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | |



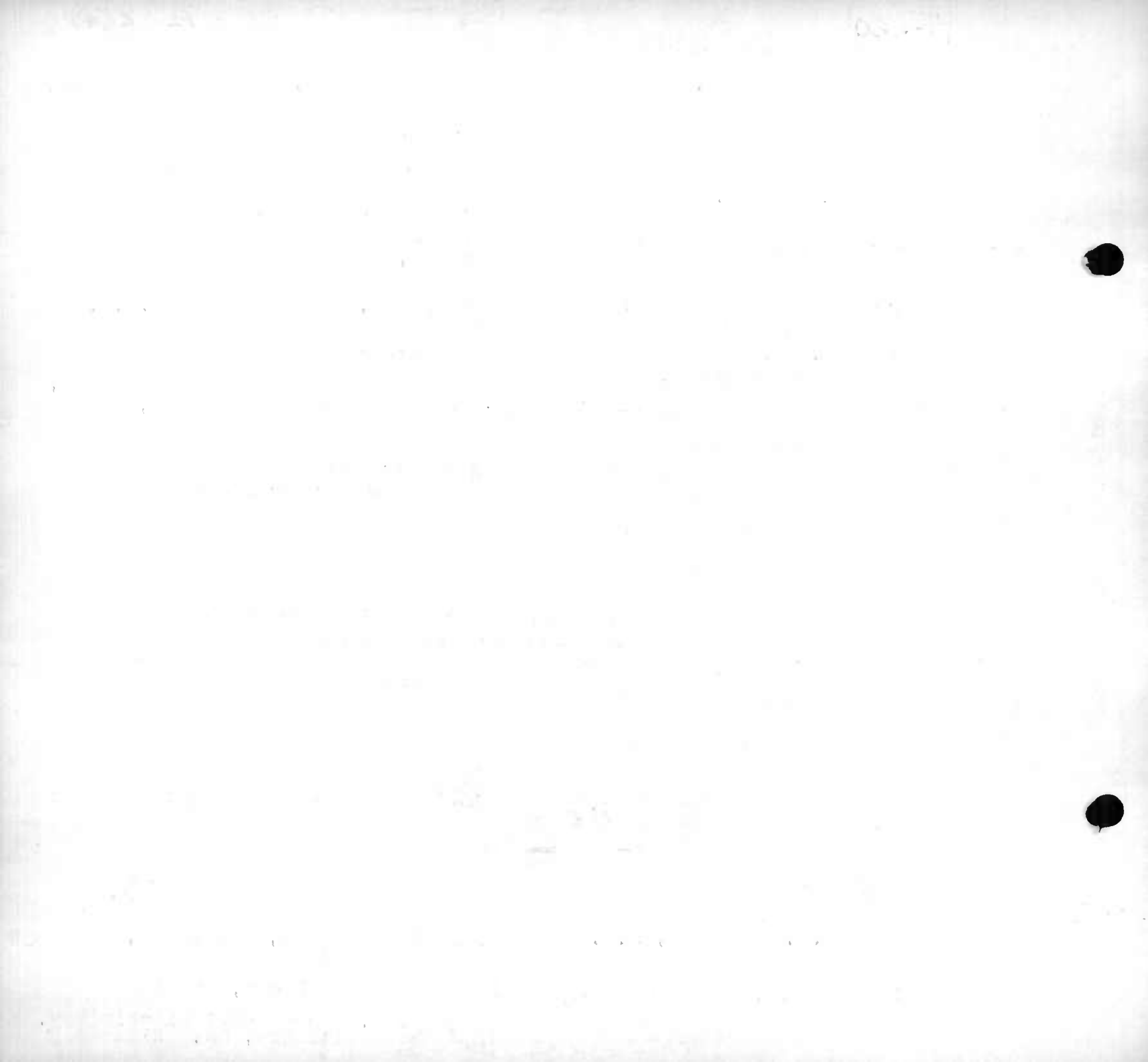
| BALTIMORE CITY HEALTH DEPARTMENT | | 71 2428 | |
|---|--|--|--|
| L-252 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | |
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) MARION LESNIEWSKI | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTO. CITY HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year March 9, 1971 4:24 A.M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH Nov. 14, 1921 | | 10. AGE (In years lost birthday) 49 | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator | | 14B. KIND OF BUSINESS OR INDUSTRY Utility | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) Yes | | 17. SOCIAL SECURITY NO. 215 14 4650 | |
| 13. FATHER'S NAME Stanley Lesniewski | | 15. MOTHER'S MAIDEN NAME Stella Czankiewicz | |
| 18. INFORMANT Doris E. Lesniewski | | ADDRESS 1340 Cambria St. 21225 | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE March 12 1971 | |
| 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | |
| 25C. FUNERAL DIRECTOR Mc Cully Funeral Home | | ADDRESS Balto. Md. 21225 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

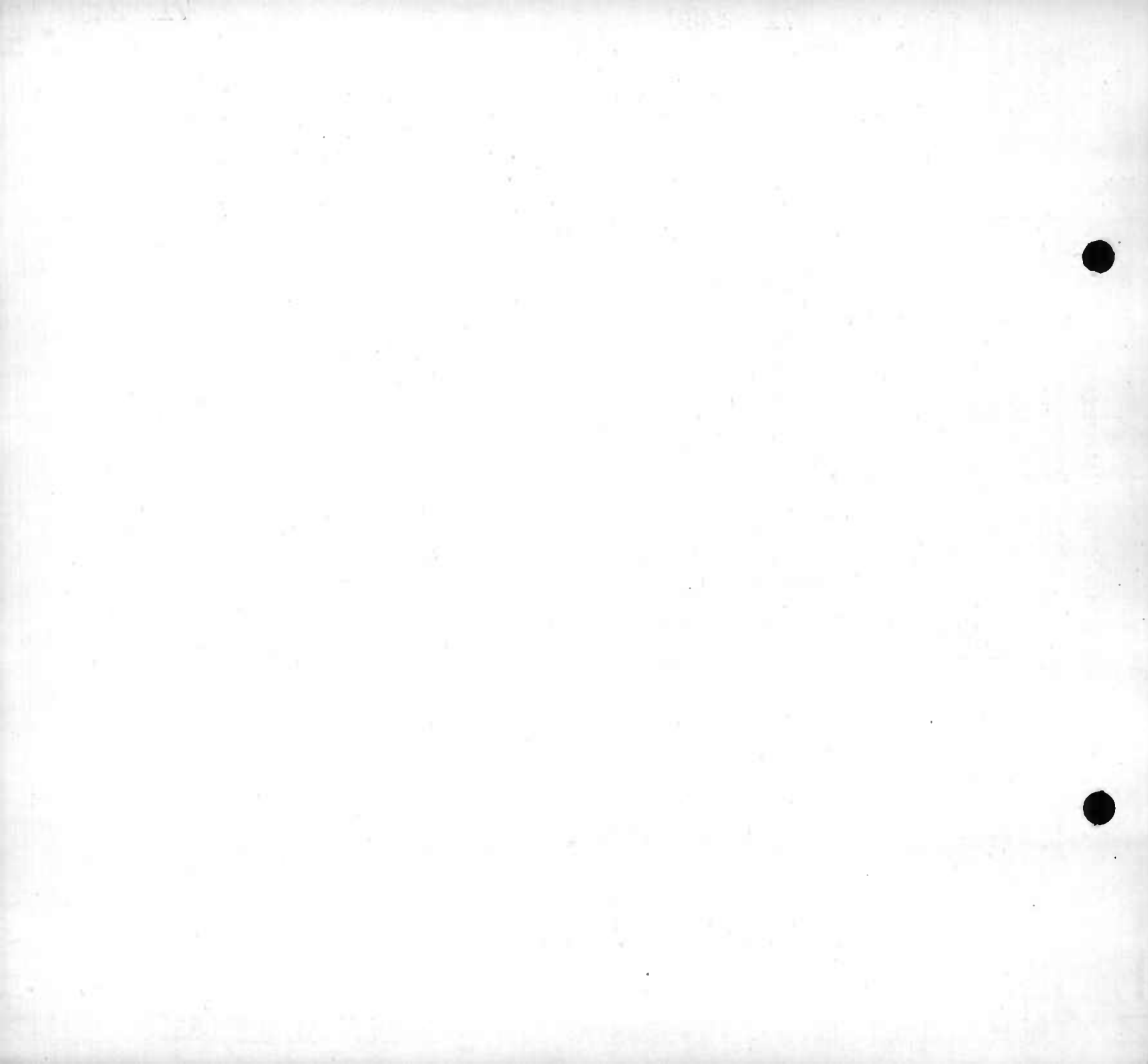
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2429 | |
|--|--|---|--|---|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Letita G. Burrier | | 2. DATE AND HOUR OF DEATH March 5, 1971 5:30 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1319 Light St. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2403 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1319 Light Street | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 12, 1889 | 9. AGE (In years lost birthday) 81 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Thomas A. Smith | |
| 14. MOTHER'S MAIDEN NAME Sara Jane Thompson | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 219 14 1965 | | | | 17. INFORMANT 1422 Light Street, Mrs Ann Fleming Baltimore, Md 21230 | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic HEART DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div> | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 1. CEREBRAL ARTERY INSUFFICIENCY 2. CHRONIC BRONCHITIS | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/11/1967 to 3/6/1971 and that in (my) (our) opinion death occurred on the date 3/6/71 and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H.P. Friedman | | | | 23B. DATE SIGNED 3/8/71 | |
| 23C. PHYSICIAN'S NAME (Type) H.P. Friedman, M.D. | | | | 23D. ADDRESS 1319 Light Street, Baltimore, Md 21230 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/71 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 25B. NAME OF REGISTRAR George J. Gonce 25C. FUNERAL DIRECTOR 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

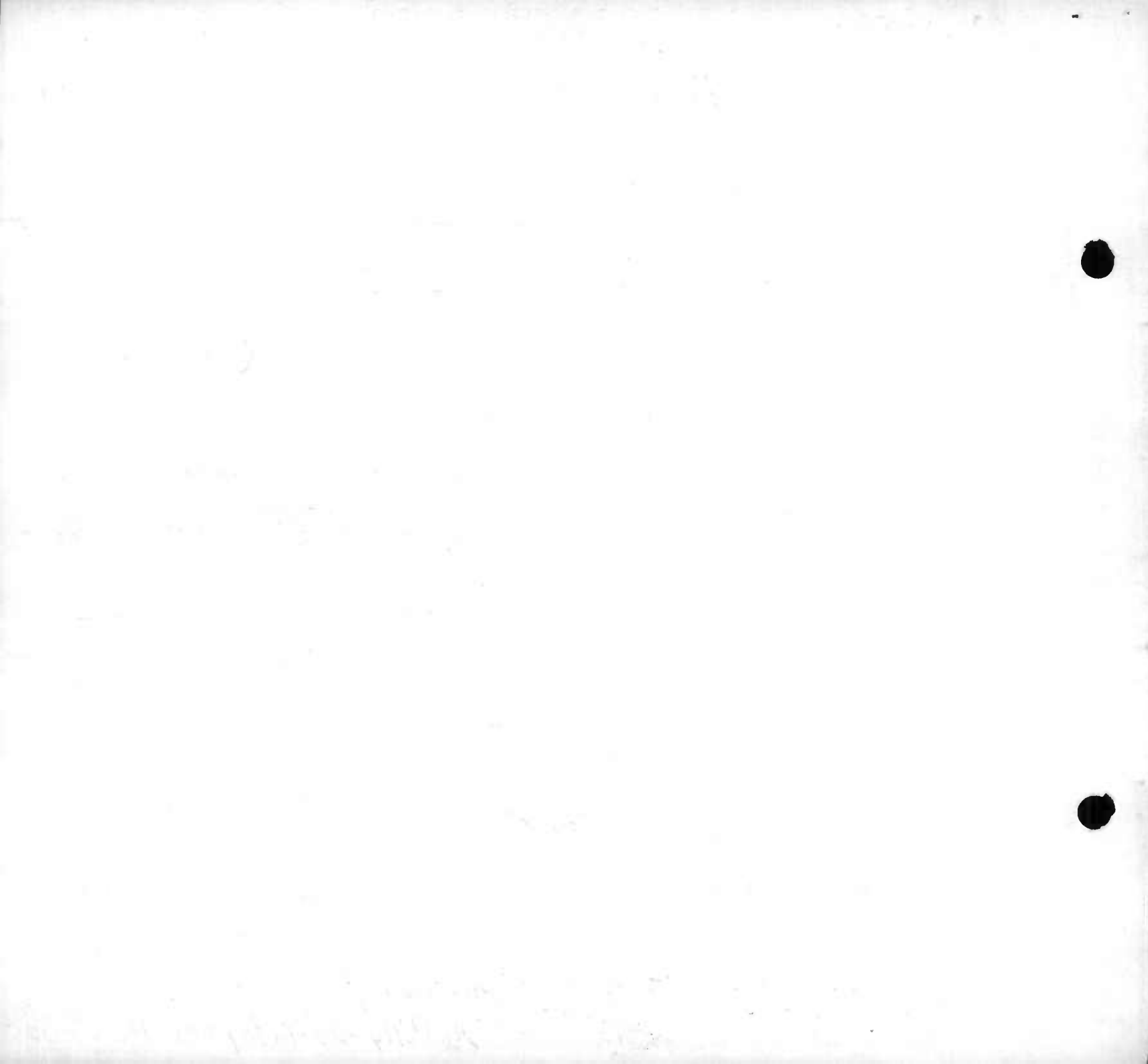
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2430 | |
|---|---------------------|---|-----------------------------------|--|--|
| M-200 71 2430 | | 71-04673 | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) BABY BOY MCCOY | | 2. DATE AND HOUR OF DEATH 3/8/71 10:10 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTO., MD. B. COUNTY 907 | | A. M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSP. | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTO | |
| | | | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 2529 Cecil Avenue | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/8/71 | 9. AGE (In years last birthday) 8 HRS | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 8 17 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Johns Hopkins Hospital | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME Dorothy McCoy | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 7269 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY APNEA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PREMATURITY | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 3/8/71 19 71 to 3/8 19 71 , that (1) (we) last saw the deceased alive on 3/8/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Peter R. Holbrook | | 23B. DATE SIGNED 3/8/71 | | 23C. PHYSICIAN'S NAME (Type) Peter Holbrook, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3/9/71 | | 24C. NAME OF CEMETERY or CREMATORY Johns Hopkins Hospital | |
| 24D. LOCATION (City, town, or county) (State) 601 N Broadway Balto., Md. | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

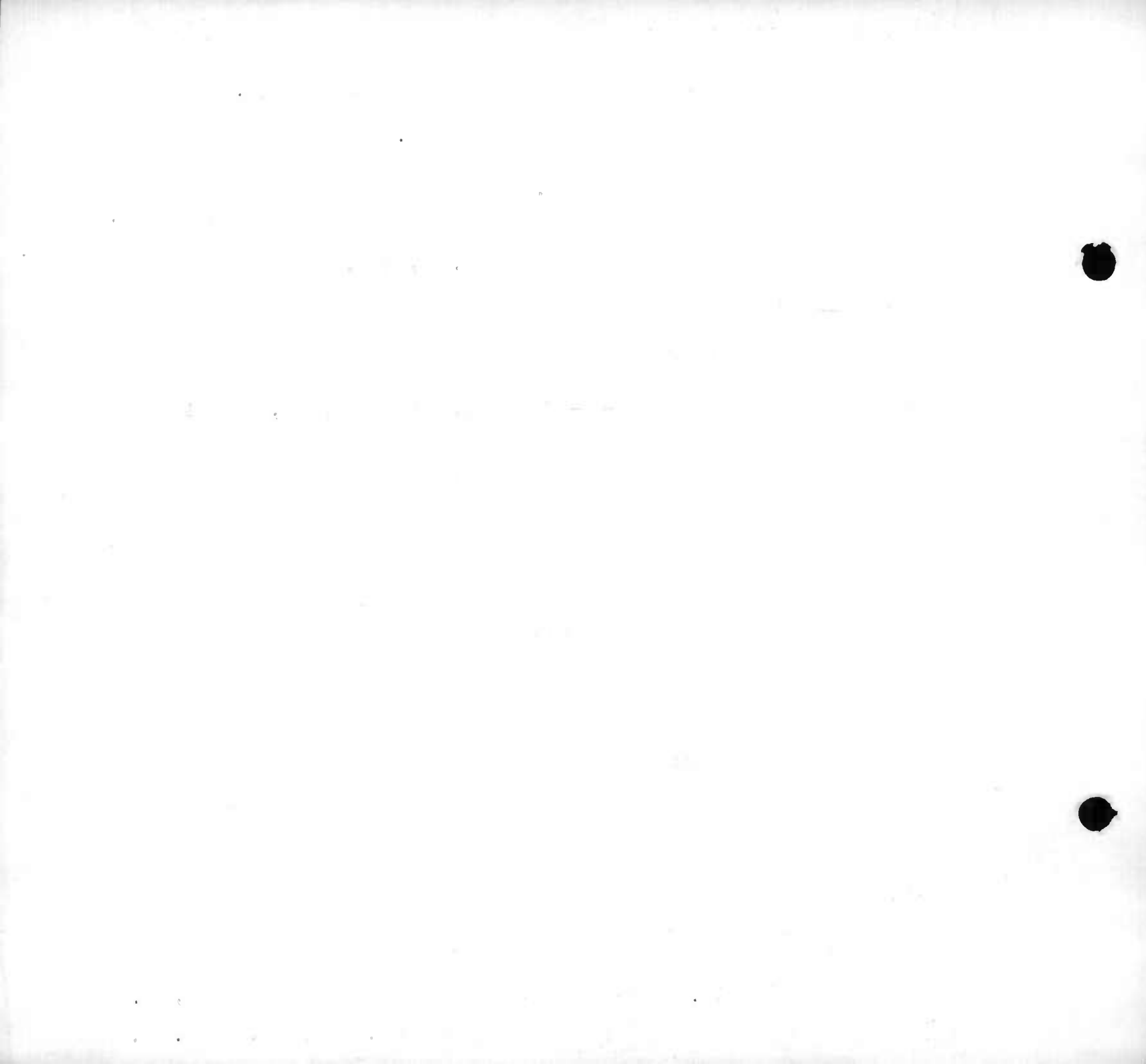
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>9181</u> <u>2431</u> | |
|---|--|--|--|---|--|
| J-520 BIRTH NO. <u>71</u> <u>2431</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>NAOMI K JONES</u> | | 2. DATE AND HOUR OF DEATH <u>MARCH 6 1971</u> <u>11:30 AM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>HARBOR VIEW NURSING HOME</u> | | A. STATE <u>MARYLAND</u> | | B. COUNTY <u>2778</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>F</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CASHIER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>10/31/1914</u> | |
| 13. FATHER'S NAME <u>GROVER C Butler</u> | | 14. MOTHER'S MAIDEN NAME <u>Christina (Riley)</u> | | 9. AGE (in years last birthday) <u>56</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>236-48-318</u> | | 17. INFORMANT <u>Chart</u> | |
| 18. <u>25071</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Vascular accident <u>myocardial infarction with right bundle branch block</u></u> | | <u>3 months</u> | |
| | | (B) <u>coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>3 months</u> | |
| | | (C) <u>diabetes mellitus</u> <u>polycythemia</u> | | <u>years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> 19 <u>71</u> to <u>3/6</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>al mabry</u> | | | | 23B. DATE SIGNED <u>3/7/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u> | | 23D. ADDRESS <u>2E Reed St Balt MD 21202</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-10-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Headsville Cemetery Keyser, W. VA.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 11 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert J. ...</u> | | 25C. FUNERAL DIRECTOR <u>McNally - 837 Patapsco Ave, 21225</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 71 2432 | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. 4-260 | | | | 71 2432 | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN E. HACKER | | | | 2. DATE AND HOUR OF DEATH MARCH 9, 1971. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines (Belair Rd.) | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto. 5300 | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 14, 1882. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired—Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) 88 | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 13. FATHER'S NAME ? Hacker | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-03-5436 | | 17. INFORMANT ADDRESS Mrs. Emily Schilling, 8135 Pleasant Plains Rd | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Coronary thrombosis Acute [minutes] | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Chronic Arteriosclerotic CardioVasc. Disease ± 30 yrs. (C) - None - | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 26 Jan 1961 to 9 March 1971 that (I) (we) last saw the deceased alive on 20 Feb 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Edward L. J. Molz, M.D. | | | | 23B. DATE SIGNED 10 March 71 | | 23C. PHYSICIAN'S NAME (Type) Edward L. J. Molz, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/12/71 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR Robert E. Sauer, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 71 2433 | |
|--|--|---|--|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> M-500 71 2433 </div> | | <div style="display: flex; justify-content: space-between;"> BIRTH NO. DATE AND HOUR OF DEATH </div> <div style="display: flex; justify-content: space-between;"> 1. NAME OF DECEASED (Type or Print) <i>James Mooney</i> 3/8/71 4:10 P.M. </div> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>48 Maryland Gen Hosp.</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1901</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>117 N. Fulton Avenue</i> | | | |
| 5. SEX <i>Male</i> 6. RACE <i>Caucasian</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>5/15/12</i> 9. AGE (In years last birthday) <i>58</i> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>operator</i> 10B. KIND OF BUSINESS OR INDUSTRY <i>Allied Chem. Co.</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | 13. FATHER'S NAME <i>James Mooney</i> 14. MOTHER'S MAIDEN NAME <i>Elizabeth Winters</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>Yes WWII</i> | | 16. SOCIAL SECURITY NO. <i>215-12-7892</i> | | 17. INFORMANT <i>Patent doctor</i> ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>metastatic Ca of lung</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>18 months</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Multi-organ Failure</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>3/5/71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/5/71</i> 19 to <i>3/8</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>3/8</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Ray W. Miller M.D.</i> | | | | 23B. DAYE SIGNED <i>3/8/71</i> | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS | | 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> 24B. DATE <i>3/12/71</i> 24C. NAME of CEMETERY or CREMATORY <i>Arbutus Mem. Park</i> 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 11 1971</i> | | 25B. NAME OF REGISTRAR <i>Blair E. Tobin</i> | | 25C. FUNERAL DIRECTOR <i>Kelson, FH</i> ADDRESS <i>1348 N. Calhoun St.</i> | | | |

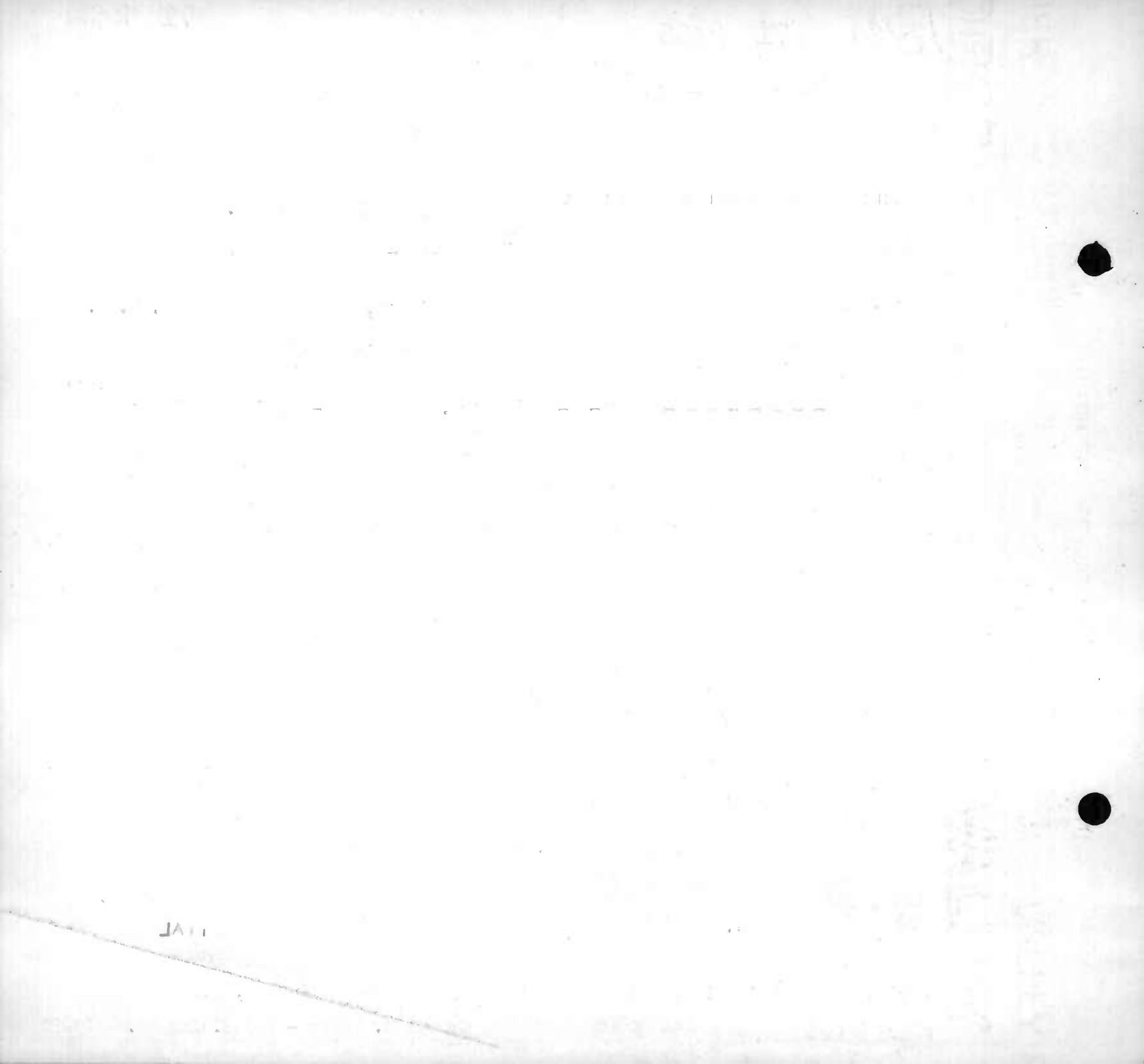
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2434 | |
|---|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. | | 71 2434 | |
| 1. NAME OF DECEASED (Type or Print) Nathaniel J. Horsey | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 3 Day 8 Year 71 Estimated <input type="checkbox"/> 3 8 71 | | Hour 9:45 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 612 W. Lafayette Street | | 3. DATE PRONOUNCED DEAD Month 3 Day 8 Year 71 | | Hour 9:45 a.m. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1402 | | 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH Mar. 16, 1900 70 | | 10. AGE (In years lost birthday) 70 | | E. STREET AND NUMBER 612 W. Lafayette Street | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Howard Horsey | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Charolette Johnson | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) Unk. | | 17. SOCIAL SECURITY NO. 214-20-7499 | | 18. INFORMANT William James 2104 Westwood Ave. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/8/71 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/12/71 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR Kelson FH 1348 N. Calhoun St. | | 25D. ADDRESS | | | |

WALL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 71 2435 |
|---|--|--|--|---|---------|
| L-120 71 2435 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) August Joseph Lavicka or Lavick | | 2. DATE AND HOUR OF DEATH 3/10/71 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS H SPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 203 | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME ANTHONY | | 14. MOTHER'S MAIDEN NAME Antonia Svehla | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-09-2696 | | 17. INFORMANT Mrs. Mary Yuhn - 8725 Avondale Road | |
| 18. 433.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH LEFT LATERAL MEOLBARY BEANSTEM INFACT (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vaso disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerotic cardiovascular disease | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 3/5 19 71 to 3/9 19 71 , that (I) (we) lost saw the deceased alive on 3/10 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE John S. Kizer MD | | 23B. DATE SIGNED 3/10/71 | | 23C. PHYSICIAN'S NAME (Type) JOHN S. KIZER | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/71 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor MD | | 25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231 | |
| 24D. LOCATION Baltimore, Maryland | | 24E. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |

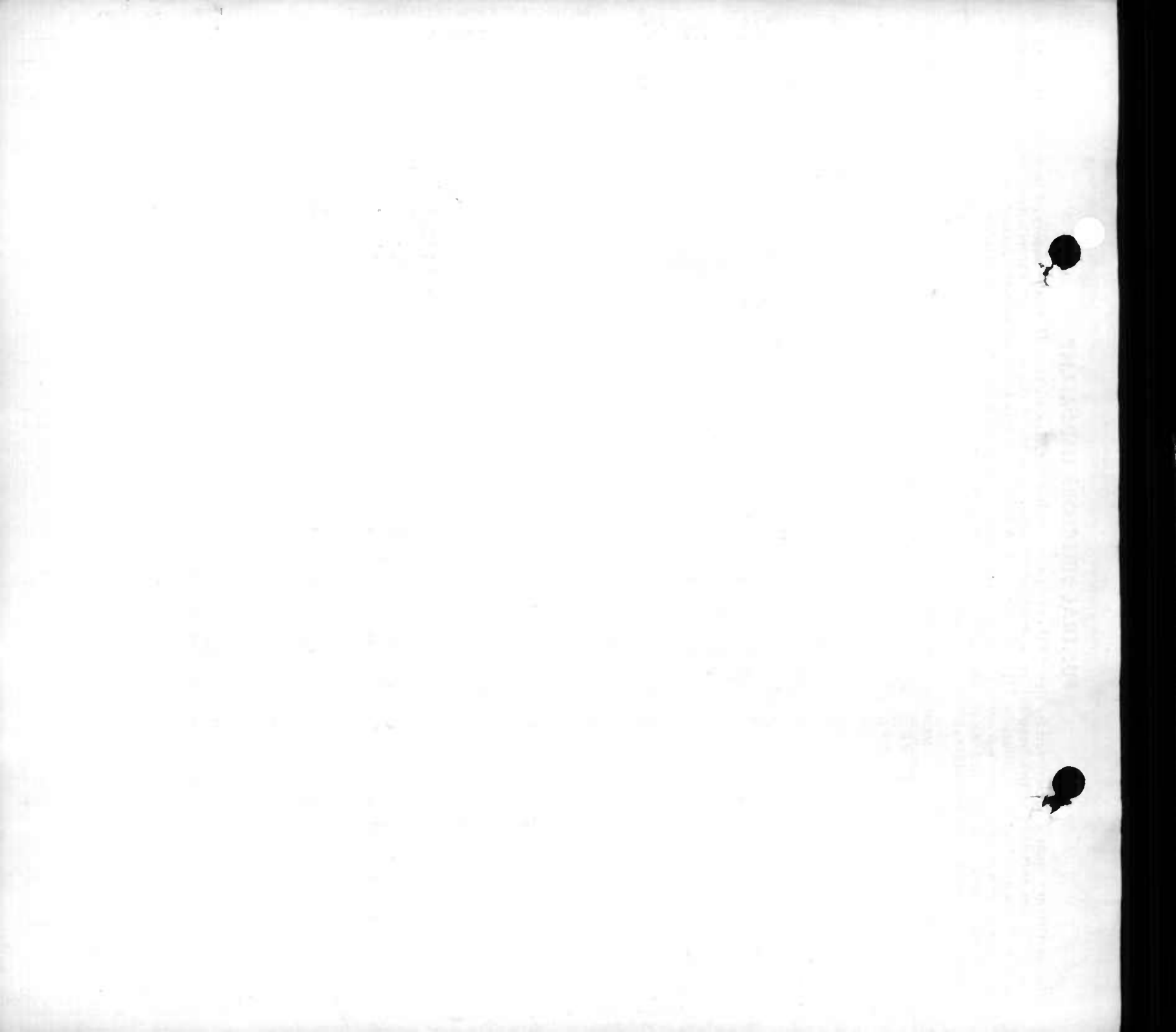


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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2436 | |
|---|--|---|---|---|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) Gholson, Ida | | 2. DATE AND HOUR OF DEATH 3-10-71 3³⁰/A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 802 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1831 N. Patterson Park Avenue | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/15/92 | 9. AGE (In years last birthday) 79 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME UNKNOWN | | | 14. MOTHER'S MAIDEN NAME Elsie Harrison | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Sandy Gholson | | | ADDRESS 1515 N. Kenwood Ave. | | |
| CAUSE OF DEATH | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary Atherosclerosis (C) DUE TO, OR AS A CONSEQUENCE OF: 1/2 Ca. of Covid // Chronic Bronchitis | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/8 19 71 to 3/10 19 71 that (I) (we) last saw the deceased alive on 3/10 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Paul Whelton M.D. MCH BAO DEGREE | | | | 23B. DATE SIGNED 3/10/71 | |
| 23C. PHYSICIAN'S NAME (Type) PAUL WHELTON M.D. MCH BAO DEGREE | | | | 23D. ADDRESS JOHNS HOPKINS HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 3-13-71 | | 24C. NAME OF CEMETERY OR CREMATORY South Hill, VA. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 25B. NAME OF REGISTRAR John M. ... 25C. FUNERAL DIRECTOR E. Hyatt ADDRESS Funeral Home 129 N. ... | | | |



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **71 2437**

BIRTH NO.

| | | | | | | | |
|--|-------------------------|--|--|--|-----|---|------|
| 1. NAME OF DECEASED (Type or Print) PHILLIP ROBERTS | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month | Day | Year | Hour |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 City Hospital | | 3. DATE PRONOUNCED DEAD Month 3 Day 9 Year 1971 Hour 7:15 p.m. | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 806 | | | |
| 6. SEX male | 7. RACE negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH 2-5-1911 | | 10. AGE (In years last birthday) 60 | | E. STREET AND NUMBER 1730 N. Chester St. | | | |
| 11. BIRTHPLACE (State or foreign country) Africa | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME unknown | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) W. W. H. | | 14B. KIND OF BUSINESS OR INDUSTRY W. W. H. | | 15. MOTHER'S MAIDEN NAME unknown | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W. W. H. | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT Viola Conway Roberts - 1730 N. Chester | | ADDRESS | |

| | | | |
|--|--|---|--|
| 19. CAUSE OF DEATH E814.1 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |

| | | | | | |
|---|--|---|--|--|--|
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) North Pt. Blvd. 1500' so. Eastern Blvd. | |
| 22D. TIME OF INJURY (APPROX.) 3-9-71 | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Pedestrian struck by auto. | |

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Isidore Mihalakis, M.D.** M.D. CHIEF MEDICAL EXAMINER ☐

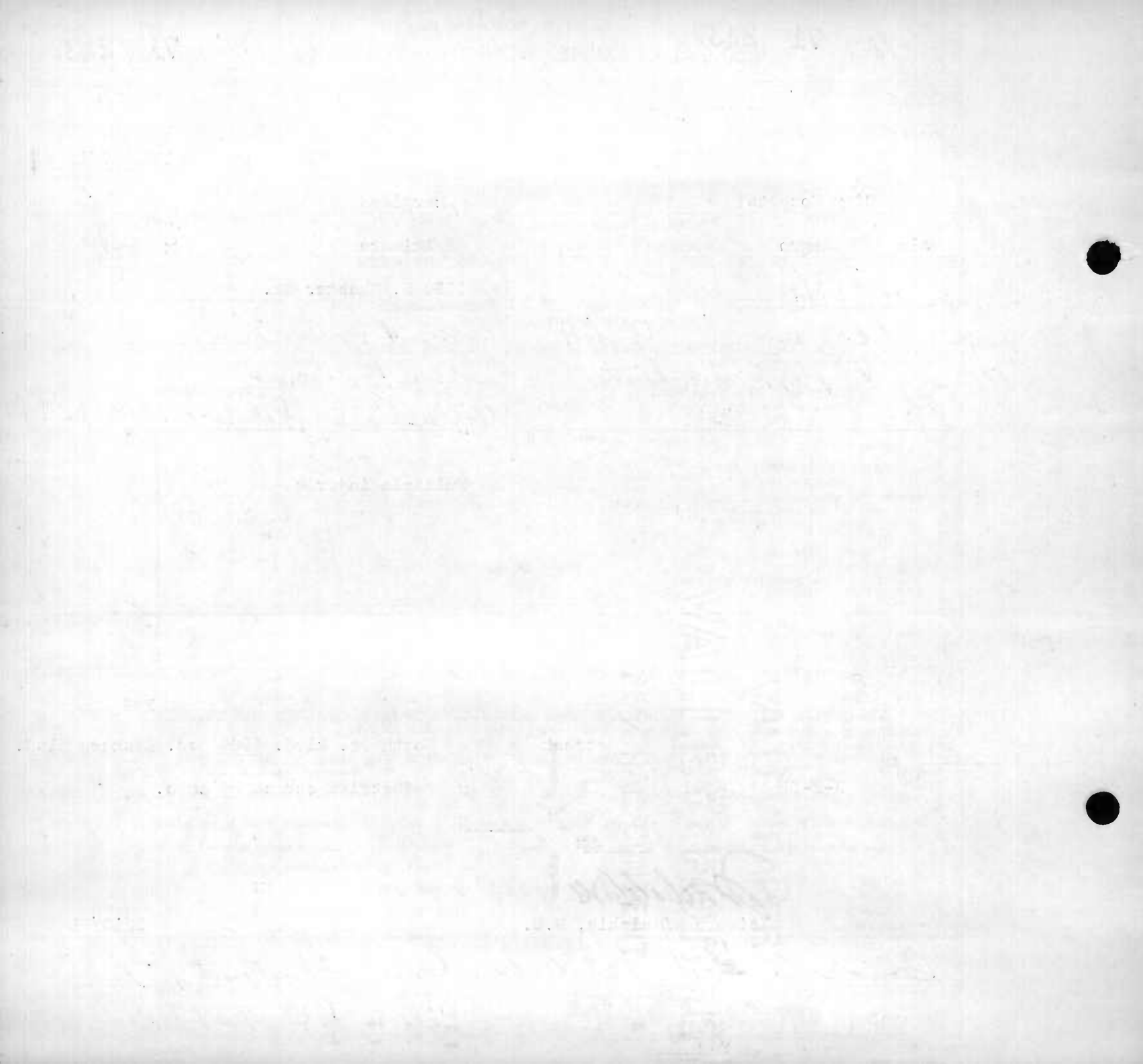
EXAMINER'S NAME (Type) **Isidore Mihalakis, M.D.** ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **3/10/71**

ASSOCIATE MEDICAL EXAMINER ☐

| | | | |
|---|-----------------------------|--|---|
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3-10-71 | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | 24D. LOCATION (City, town, or county) (State) Westport, Md. |
|---|-----------------------------|--|---|

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|---|---|---|---------------------------------------|
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | 25C. FUNERAL DIRECTOR Elliott G. H. | ADDRESS 112971 Carlisle St. |
|---|---|---|---------------------------------------|

VS 151-REV. 1/1/68



| BIRTH NO. | | 71 2438 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. 71 2438 | |
|---|--|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) BENNY CUSTUS | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | | | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1076 Fairmount Ave. | | | | 3. DATE PRONOUNCED DEAD Month Day Year 3 9 1971 | | Hour 2:10 p.m. | | | |
| 6. SEX male | | | | 7. RACE negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1802 | |
| 9. DATE OF BIRTH 8/3/00 | | 10. AGE (In years lost birthday) 70 | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME ??? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher | | | | 14B. KIND OF BUSINESS OR INDUSTRY Construction | | 15. MOTHER'S MAIDEN NAME ??? | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 17. SOCIAL SECURITY NO. 226-09-7209 | | 18. INFORMANT ADDRESS Mrs Annia Mae Briscoe, Same | | | |
| 19. 4124 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 20A. DATE OF OPERATION 0 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalkis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/10/71 | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/71 | | 24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) A A County Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR Isidore Mihalkis, M.D. | | 25C. FUNERAL DIRECTOR Adolphus Halstead | | ADDRESS 1206 W 14th St Ave | | | |

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| 71 2439 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2439 | |
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| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES PIERCE | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4611 Garrison Ave. | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 3 10 1971 7:15 a.m. | |
| 6. SEX male | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1510 | |
| 7. RACE negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH 10-15-22 | | 10. AGE (In years lost birthday) 49 | | E. STREET AND NUMBER 4611 Garrison Ave. | |
| 11. BIRTHPLACE (State or foreign country) Roxboro, N. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Josephs Brooks | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Esther Barksdale | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT Mrs. Lona Pierce ADDRESS 319 Grantley Street | |
| 19. 57101 CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE Fatty liver DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (C) | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) PARTIAL | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. Part. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 3/10/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-71 | | 24C. NAME of CEMETERY or CREMATORY Burchwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Roxboro, N. C. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR John E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Morton & Dyett F. H. ADDRESS Balto, Md. 21217 1701 Laurens St. | |

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WALKER, F. C.

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71 2440

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2440

BIRTH NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JOHN BLACK | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 3 9 1971 3:20 p.m. | | | |
| 6. SEX male | | | | 7. RACE negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH 6-18-38 | | | | 10. AGE (In years last birthday) 32 | | 11. BIRTHPLACE (State or foreign country) Spring Grove, Va. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 13. FATHER'S NAME Andrew Black | | 14. MOTHER'S MAIDEN NAME Celestine Moore | |
| 15. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE Maryland B. COUNTY 1511 | | | | 16. CITY OR TOWN Baltimore | | | |
| 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 18. STREET AND NUMBER 4061 Anne Ellen Rd. | | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 20. SOCIAL SECURITY NO. | | 21. INFORMANT Celestine King | |
| 22. ADDRESS 5300 Wayne Avenue | | | | 23. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 24. DATE OF OPERATION 2 | | | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 26. AUTOPSY? (Yes or No) yes | | | | 27. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | |
| 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street | | | | 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Park Heights & ColdSpring Lane 1513 | | | |
| 30. TIME OF INJURY (Approx.) 3-9-71 2:55 p.m. | | | | 31. HOW DID INJURY OCCUR? Pedestrian struck by auto. | | | |
| 32. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | 33. ACTUAL SIGNATURE Isidore Mihalakis, M.D. | | | |
| 34. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 35. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 36. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | 37. DATE SIGNED 3/10/71 | | | |
| 38. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 39. DATE 3-13-71 | | | |
| 40. NAME OF CEMETERY or CREMATORY Braxton Cemetery | | | | 41. LOCATION (City, town, or county) (State) Spring Grove, Virginia | | | |
| 42. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | | | 43. NAME OF REGISTRAR Isidore Mihalakis | | | |
| 44. FUNERAL DIRECTOR Morton & Dyett F. H. | | | | 45. ADDRESS 1701 Laurens St. Balto, Md. 21217 | | | |

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FUNERAL DIRECTOR: IMPORTANT

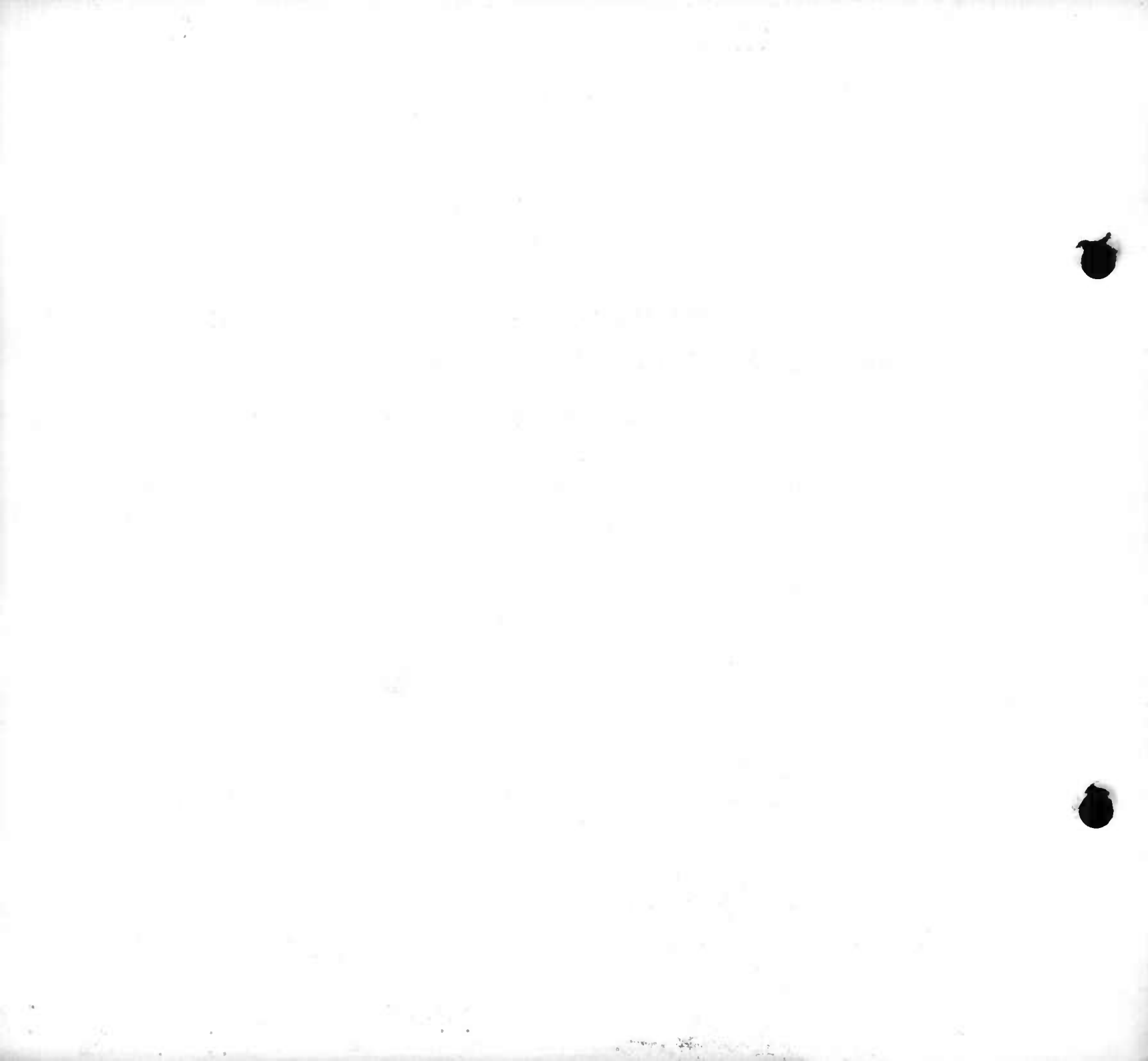
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------|--|------------------------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 71 2441 | | 71 2441 | |
| BIRTH NO. 11-640 | | 71 2441 | | REGISTERED NO. | |
| M.E. CASE NO. | | 71 2441 | | 71 2441 | |
| 1. NAME OF DECEASED (Type or Print) HARVEY A. MARLEY | | 2. DATE AND HOUR OF DEATH 3/10/71 10³⁰ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 903 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP. BALTO MD. 21201 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 21218 | | | |
| | | D. STREET ADDRESS (If rural, give location) 632 EAST 35TH ST. | | | |
| 5. SEX M | 6. RACE Can | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 9/24/97 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - INSURANCE | | 10B. KIND OF BUSINESS OR INDUSTRY UNDERWRITER | | 11. BIRTHPLACE (State or foreign country) TOWSON MD. | |
| 12. CITIZEN OF WHAT COUNTRY? USA. | | 13. FATHER'S NAME JAMES A. MARLEY | | | |
| 14. MOTHER'S MAIDEN NAME HELEN A. SAVIN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES | | | |
| 16. SOCIAL SECURITY NO. 215-03-548 | | 17. INFORMANT ADDRESS MRS. ELLEN B. MARLEY (SAME) | | | |
| 18. 279X I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Bronchopneumonia DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Pediculodactylidosis DUE TO | | | |
| | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/15/71 to 3/10/71 , that (I) (we) last saw the deceased alive on 3/10/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donald T. Lewers MD | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/10/71 | |
| 23C. PHYSICIAN'S NAME (Type) DONALD T. LEWERS MD | | 23D. ADDRESS MD. GEN HOSP BALTO MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-12-71 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, | | (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4995 York Road Balto., Md. 21212 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

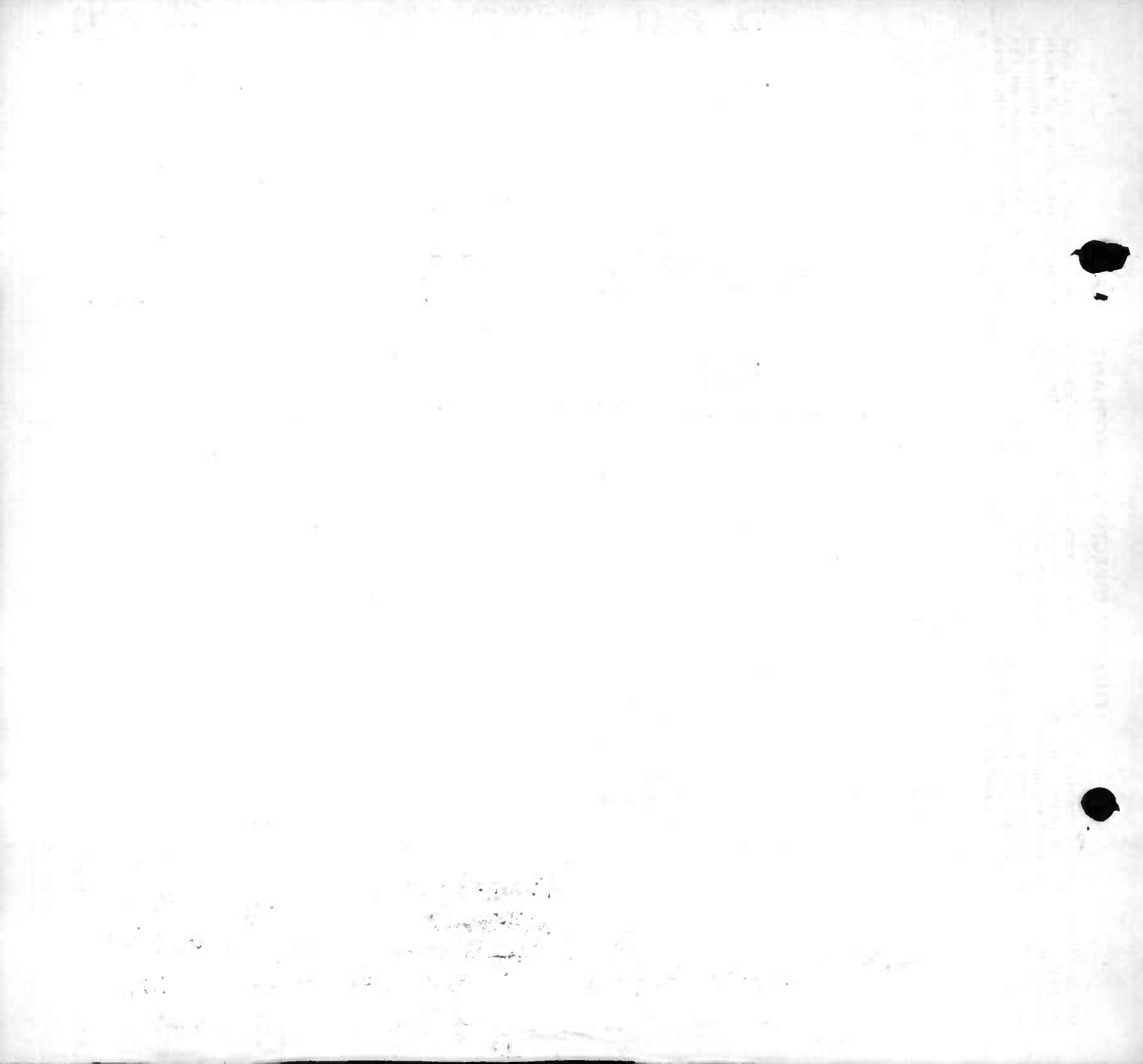
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2442 | |
|--|---|---|---|---|---|
| 71 2442 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. C-452 | | | | | |
| 1. NAME OF DECEASED (Type or Print) ANNA BELLE COLLINS | | | 2. DATE AND HOUR OF DEATH MAR. 10/1971 9:45P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD EDGEWOOD NURSING HOME | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2749 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) EDGEWOOD NURSING HOME | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 1512 PENTRIDGE RD | | |
| 5. SEX F | 6. RACE CAU | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/23/1890 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LIBRARIAN RETIRED-CITY | | 10B. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MD | | 11. BIRTHPLACE (State or foreign country) U.S.A | |
| 13. FATHER'S NAME CHARLES H. COLLINS | | | 14. MOTHER'S MAIDEN NAME ISABELLE HILTZ | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 220-44-7006 | | 17. INFORMANT MRS. DOROTHY W. EARP 21212 | |
| 18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 1 Arteriosclerotic Heart (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis recent ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2 left Hemiplegia 3 genl arteriosclerosis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 4, 1968 to Mar 10, 1971 that (I) (we) last saw the deceased alive on Mar 9, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donato W. Mintzer | | | | 23B. DATE SIGNED 3/10/71 | |
| 23C. PHYSICIAN'S NAME (Type) DONATO W. MINTZER | | 23D. ADDRESS 3009 EVERGREEN AVE BALTO MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial... | 24B. DATE 3/13/71 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE RECD BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR Rosa E. Kelly, Jr. | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| C-200 71 2443 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2443 | |
|---|---------------------|---|--|---|--|---|------------------------------|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Emery C. Cook | | | | 2. DATE AND HOUR OF DEATH March 9, 1971 12:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL | | | | A. STATE Ma | | B. COUNTY 2653 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3946 Southclaire Rd | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-22-05 | 9. AGE (in years lost birthday) 65 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Security Guard | | 11. BIRTHPLACE (State or foreign country) Ga. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry J. Cook | | | | 14. MOTHER'S MAIDEN NAME Jessie Clay | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 259-05-7731 | | 17. INFORMANT ADDRESS Mrs. Brenda Deems, 2924 Wymans | | | |
| 18. 273.21 CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hemochromatosis | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Jam dice | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 3-9-71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-27 19 71 to 3-9 19 71 that (I) (we) last saw the deceased alive on 3-9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Boo Keun Kim DEGREE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-9-71 | |
| 23C. PHYSICIAN'S NAME (Type) Boo Keun Kim DEGREE | | | | 23D. ADDRESS Mercy Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3/11-71 | | 24C. NAME of CEMETERY or CREMATORY PARKWOOD | | 24D. LOCATION (City, town, or county) (State) PARKVILLE BALTO, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR John E. Kelly | | 25C. FUNERAL DIRECTOR Frank W. Seitz | | ADDRESS 814 W 36th St | |



B-655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2444

| | | | |
|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) JAMES BRENNANN | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 502 W. Fayette St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 19 1971 8:50 a.m. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 402 | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX male | 7. RACE white | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH | 10. AGE (In years last birthday) 78 | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS | |
| 19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) PARTIAL | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. Part. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-19-71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3-9-71 | |
| 24C. NAME OF CEMETERY | | 24D. NAME OF CEMETERY | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 Robert E. Faber, M.D. | | 25B. NAME OF REGISTRAR | |

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

1955

STANDARD CHARTER BANK

17

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

E-363

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2445

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JAMES EDWARDS | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 20, 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour January 20, 1971 2:17 P.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 301 | |
| 9. DATE OF BIRTH | | 10. AGE (In years lost birthday) 60 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS | |
| 19. 412, 41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 21, 1971 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3-9-71 | |
| 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (If in Baltimore City, give exact location) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCD

TO THE HONORABLE SECRETARY OF AGRICULTURE, WASHINGTON, D. C.

FROM THE HONORABLE SECRETARY OF AGRICULTURE, WASHINGTON, D. C.

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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Q-500

71 2446

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2446

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) COMIE QUEEN | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2116 St. Paul St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 2 25 1971 1:54 p.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 12 06 | |
| 9. DATE OF BIRTH 10. AGE (In years lost birthday) 58 | | C. CITY OR TOWN Balto. | |
| 11. BIRTHPLACE (State or foreign country) | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 12. CITIZEN OF WHAT COUNTRY? | | E. STREET AND NUMBER 2116 St. Paul St. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS | |
| 19. 485X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-26-61 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 3-9-71 | | 24B. DATE 3-9-71 | |
| 24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND | | 24D. NAME OF CEMETERY LOCATION (City or county, State) UNIVERSITY MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 11 1971 | | 25B. NAME OF REGISTRAR MORTUARY SERVICE - BCHD | |

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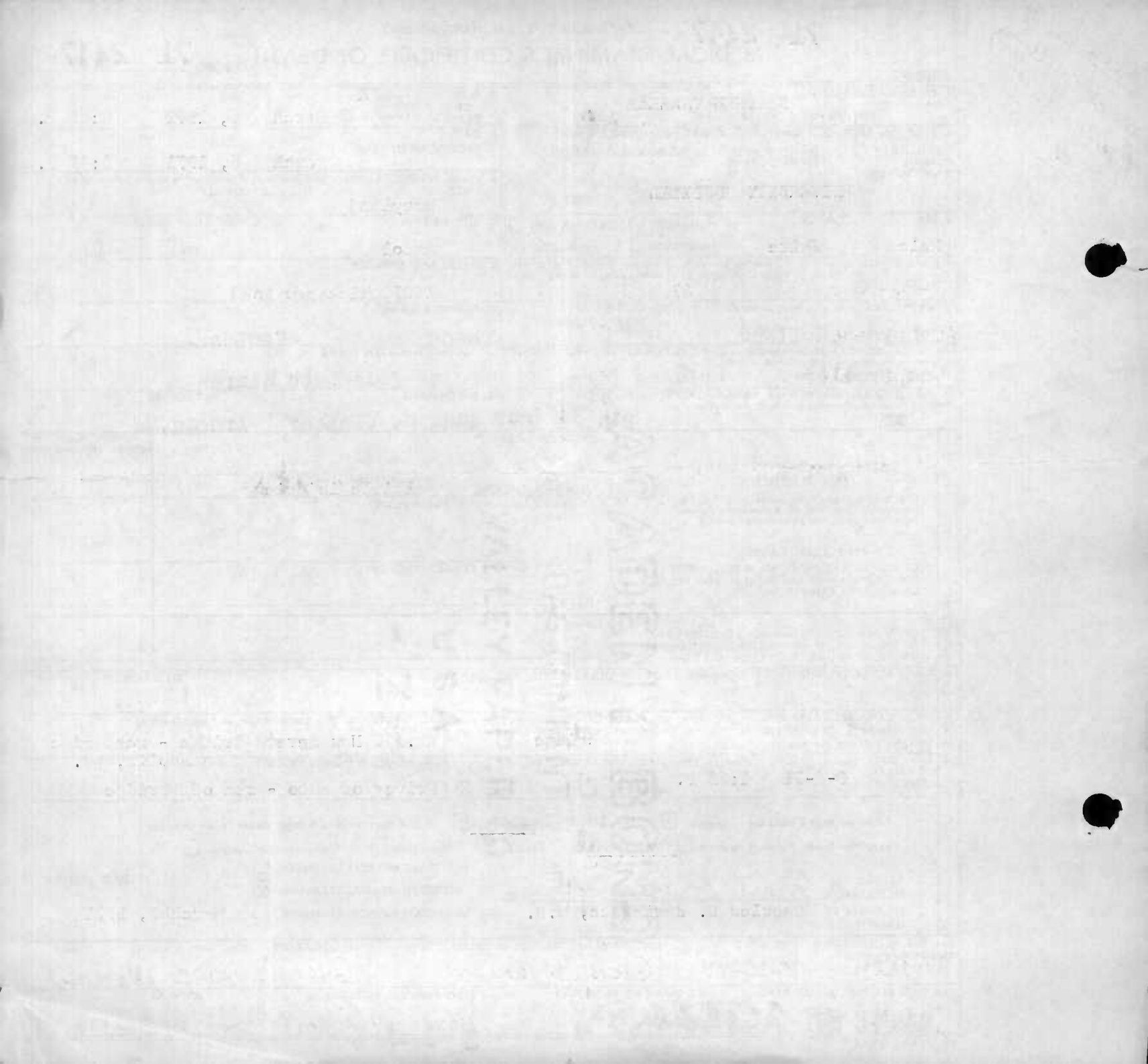
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Please note
Correct spelling
of name is in
red

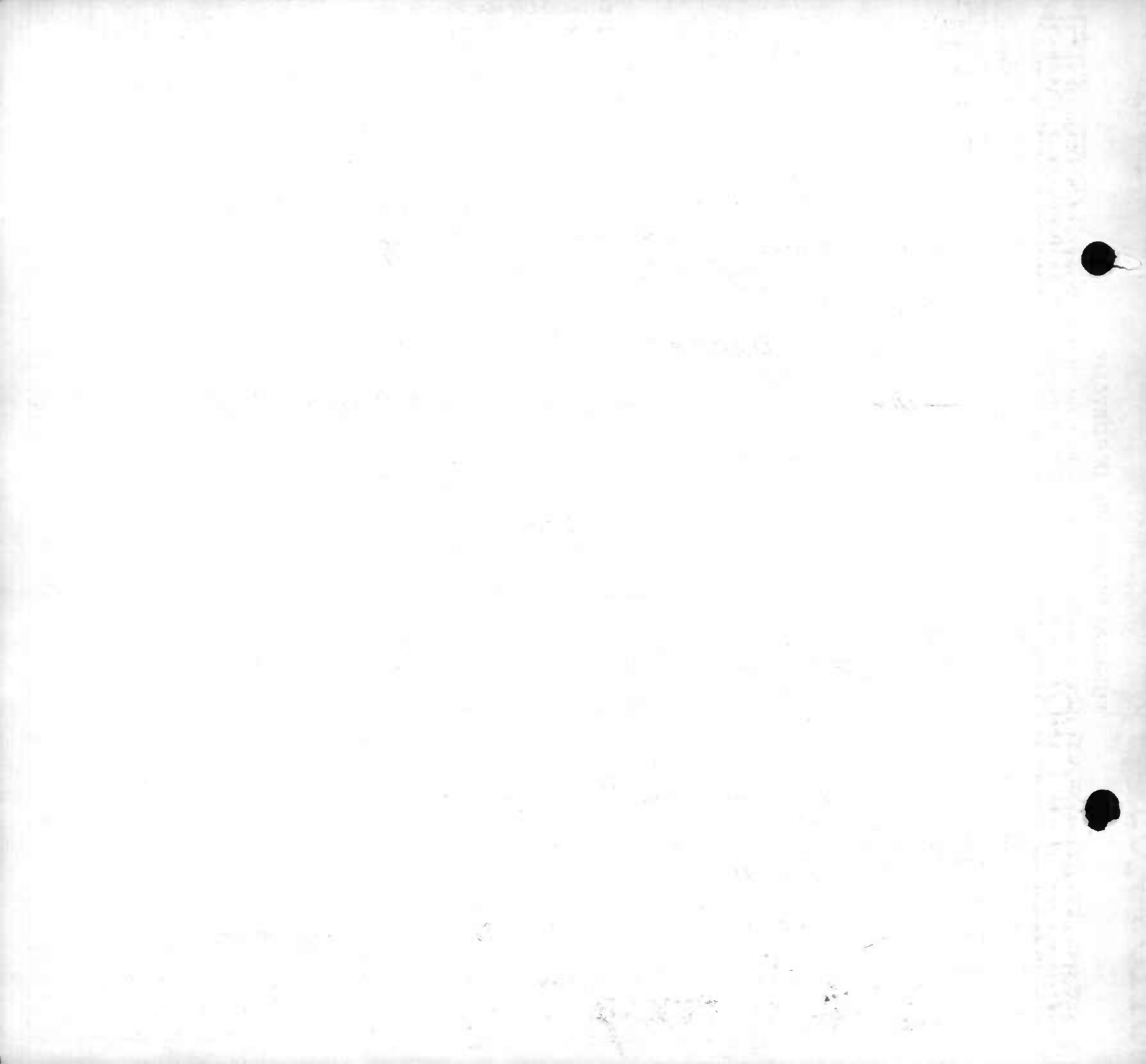
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2447 | | | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. <u>V-546</u> <u>71</u> <u>2447</u> | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>STEPHEN VANLEAR</u> | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>March</u> Day <u>6</u> Year <u>1971</u> Hour <u>4:45 P.M.</u> | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 UNIVERSITY HOSPITAL</u> | | | | 3. DATE PRONOUNCED DEAD Month <u>March</u> Day <u>6</u> Year <u>1971</u> Hour <u>4:45 P.M.</u> | | | |
| 6. SEX <u>Male</u> | | | | 7. RACE <u>White</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH <u>7-26-23</u> | | | | 10. AGE (In years last birthday) <u>47</u> | | 11. BIRTHPLACE (State or foreign country) <u>Amsterdam, Holland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Thede VanLaar</u> | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comptroller</u> | | | | 15. MOTHER'S MAIDEN NAME <u>Louise Elizabeth Klare</u> | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | 17. SOCIAL SECURITY NO. <u>214 38 4687</u> | | 18. INFORMANT <u>Anna C. VanLaer</u> | |
| 19. <u>58 16.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20A. DATE OF OPERATION <u>2</u> | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) <u>Yes</u> | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Bridge</u> | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>Rt. #50 New Severn Bridge - west side</u> | | | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <u>3-6-71 1:45 P.</u> | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? <u>Driver of auto - ran off bridge</u> | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Charles S. Springate, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DATE SIGNED <u>March 7, 1971</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-10-71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven</u> | | 24D. LOCATION (City, town, or county) (State) <u>Glen Burnie MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Springate</u> | | 25C. FUNERAL DIRECTOR <u>Hardesty Funeral Home</u> | | ADDRESS <u>Annapolis, Md</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

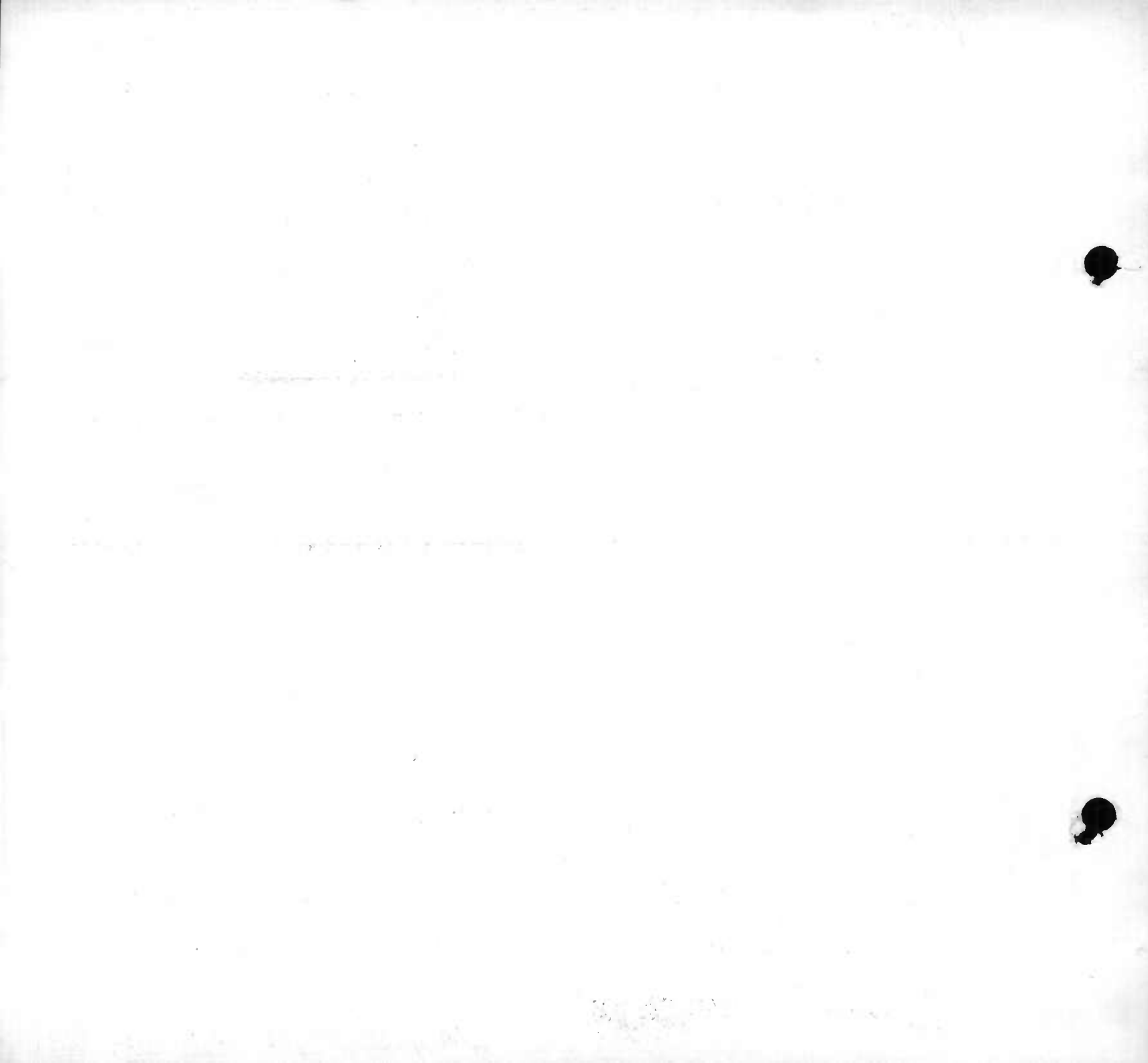
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. <u>71 2448</u> | |
|--|--------------|--|------------------|---|-----------------------|--|------------------------|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | | | |
| <u>DRAPER MERWIN Thomas</u> | | <u>3/10/71 at 4⁰⁵ AM</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | A. STATE B. COUNTY | | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | MILLERSVILLE - MARYLAND <u>5200</u> | | | |
| <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| <u>33001 SOUTH HANOVER ST. - BALTIMORE</u> | | | | <u>MILLERSVILLE 21108</u> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER | | | | <u>107 ROL PARK TRAILER VILLAGE</u> | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 To Months | 11. Under 24 Hrs. Days | 12. Under 24 Hrs. Min. |
| <u>MALE</u> | <u>WHITE</u> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <u>3-3-09</u> | <u>63</u> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>MANAGER</u> | | <u>AUTO TRANSPORT</u> | | <u>MICHIGAN</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>WARREN DRAPER</u> | | | | <u>MAUDE SMITH</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| <u>NO</u> | | <u>369-01-4652</u> | | <u>FERN B. DRAPER</u> | | <u>Millersville Md. 21108</u> | |
| 18. <u>42701</u> CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | <u>RESPIRATORY ACIDOSIS</u> | | | |
| ANTECEDENT CAUSES | | | | (B) <u>CHF</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) _____ | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| <u>0</u> | | <u>✓</u> | | <u>NO</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| <input type="checkbox"/> | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> 19 <u>71</u> to <u>MARCH 10</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>MARCH 10</u> 19 <u>71</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>W. Weiss</u> M.D. | | | | 23B. DATE SIGNED <u>3/10/71</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>WEISS</u> | | | | 23D. ADDRESS <u>SOUTH BALTO GEN. Hosp.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>3/13/71</u> | | <u>EVERGREEN CEM.</u> | | <u>LANSING Mich.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| <u>MAR 12 1971</u> | | <u>R. E. ...</u> | | <u>E. J. MacNabb</u> | | <u>301 Frederick Rd BALTO Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2449 | |
|---|--|---|---|---|--|
| BIRTH NO. P-350 71 2449 | | 1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">Jo Ann Patton</div> | | 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> Mar. 8, 1971 8: 05 A M. </div> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> FULL NAME OF HOSPITAL OR INSTITUTION <div style="font-size: 1.2em;">US Public Health Service Hospital 3100 Wyman Parkway</div> </div> <div style="width: 40%;"> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> A. STATE <div style="font-size: 1.2em;">Md. Frederick</div> </div> <div style="width: 40%;"> B. COUNTY <div style="font-size: 1.2em;">6000</div> </div> </div> | | |
| 5. SEX <div style="display: flex; justify-content: space-around;"> F W </div> | | | 6. RACE <div style="display: flex; justify-content: space-around;"> W </div> | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <div style="font-size: 1.2em;">6/22/27</div> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">Housewife</div> | | | 11. BIRTHPLACE (State or foreign country) <div style="font-size: 1.2em;">Md.</div> | | |
| 13. FATHER'S NAME <div style="font-size: 1.2em;">Harold L. Phelps</div> | | | 14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em;">Marjorie E. Shauck</div> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="font-size: 1.2em;">No</div> | | | 16. SOCIAL SECURITY NO. <div style="font-size: 1.2em;">212-24-6467</div> | | |
| 17. INFORMANT <div style="font-size: 1.2em;">Records- US PHS Hospital, Balto, Md.</div> | | | ADDRESS | | |
| 18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <div style="font-size: 1.2em;">Bronchopneumonia</div> </div> <div style="width: 40%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.2em;">Days</div> </div> </div> | | | | | |
| 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.2em;">Disseminated lymphosarcoma</div> </div> <div style="width: 40%;"> 14 yrs. </div> </div> | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <div style="font-size: 1.2em;">2</div> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <div style="font-size: 1.2em;">yes</div> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 16</u> 19 <u>71</u> to <u>Mar. 8</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>Mar. 8</u> 19 <u>71</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <div style="font-size: 1.5em;">Gary E. Feldman, M.D.</div> | | | | 23B. DATE SIGNED <div style="font-size: 1.2em;">3/8/71</div> | |
| 23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em;">Gary E. Feldman, Surg (R)</div> | | | | 23D. ADDRESS <div style="font-size: 1.2em;">US PHS Hospital, Balto, Md.</div> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em;">Burial</div> | | 24B. DATE <div style="font-size: 1.2em;">3-11-71</div> | | 24C. NAME OF CEMETERY or CREMATORY <div style="font-size: 1.2em;">Springfield Cemetery</div> | |
| 24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.2em;">Lysacville Md.</div> | | 25A. DATE REC'D BY HEALTH DEPT. <div style="font-size: 1.2em;">MAR 12 1971</div> | | | |
| 25B. NAME OF REGISTRAR <div style="font-size: 1.2em;">R. E. Haight</div> | | 25C. FUNERAL DIRECTOR <div style="font-size: 1.2em;">R. E. Haight</div> | | | |
| ADDRESS <div style="font-size: 1.2em;">Lysacville, Md.</div> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|--|---|
| 1. NAME OF DECEASED (Type or Print) McFADDEN, EDWARD R. | | 2. DATE AND HOUR OF DEATH 5 March 71 1130 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIV. of Md HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3822 S. GREENE ST. BALTO. MD 21201 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY KENT C. CITY OR TOWN CHESTERTOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER EASTERN SHORE STATE HOSP. | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 04-27-21 9. AGE (In years last birthday) 49 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | |
| 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES H. McFADDEN | | 14. MOTHER'S MAIDEN NAME RACHEL J. BOYD | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT | | ADDRESS | |
| 18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH MASSIVE HEMORRHAGE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 wks (B) CHEST TUBE-ERODING ARTERY DUE TO, OR AS A CONSEQUENCE OF: (C) PULMONARY SEPSIS 2 wks | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED upper lobe Bleb. | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2 March 71 to 5 March 71 that (I) (we) last saw the deceased alive on 5 March 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Francis A. Bartek MD | | 23B. DATE SIGNED 5 March 71 | |
| 23C. PHYSICIAN'S NAME (Type) FRANCIS A. BARTEK MD | | 23D. ADDRESS UNIV. of Md HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/9/71 | 24C. NAME OF CEMETERY OR CREMATORY Hopewell | 24D. LOCATION (City, town, or county) (State) Port Deposit, Cecil, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | 25B. NAME OF REGISTRAR James E. McMiller | 25C. FUNERAL DIRECTOR James E. McMiller ADDRESS Rising Sun, Md. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 71 2451 | |
|--|---|---|---|--|-----------------------|---|-----------------------|
| BIRTH NO. R-360 | | | | DATE AND HOUR OF DEATH March 8, 1971 1:15 A.M. | | | |
| 1. NAME OF DECEASED (Type or Print) ROEDER MARY | | | | 2. DATE AND HOUR OF DEATH | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME HOSPITAL 35 BALTO MD 21231 | | | | A. STATE BALTO BALTO B. COUNTY 5300 | | | |
| | | | | C. CITY OR TOWN BALTO | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 1205 RIDGESHIRE ROAD | | | |
| 5. SEX FEMALE | 6. RACE AMERICAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-05-99 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY H-WIFE | | 11. BIRTHPLACE (State or foreign country) POLAND MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME VINCENT KURZUK | | | | 14. MOTHER'S MAIDEN NAME MARY CROSS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213 01 2236 | | 17. INFORMANT ADDRESS Dorothy Roeder 1205 Ridgeshire Rd | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEMORRHAGE WHILE ON ANTICOAGULANT THERAPY | | | | CAUSE OF DEATH HEMORRHAGE WHILE ON ANTICOAGULANT THERAPY | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension & Atherosclerosis | | | | DUE TO, OR AS A CONSEQUENCE OF: Hypertension & Atherosclerosis | | DUE TO, OR AS A CONSEQUENCE OF: Hypertension & Atherosclerosis | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Atherosclerotic Heart Disease | | | | | | Indefinite | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home & Hospital | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) (SEE ABOVE) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) MARCH 71 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Hemorrhage while on anticoagulant therapy | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 6 19 71 to March 8 19 71 that (I) (we) last saw the deceased alive on March 8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Rolando A. Mendoza, M.D. | | | | 23B. DATE SIGNED 3/8/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) ROLANDO A. MENDOZA, M.D. | | | | 23D. ADDRESS 100 N. Broadway St, Balto, MD, 21231 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-11-71 | | 24C. NAME of CEMETERY or CREMATORY St Stanislaus Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR Robert E. Jaber, M.D. | | 25C. FUNERAL DIRECTOR WALTER DABROWSKI | | ADDRESS 1005 DUNDALK AVENUE | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

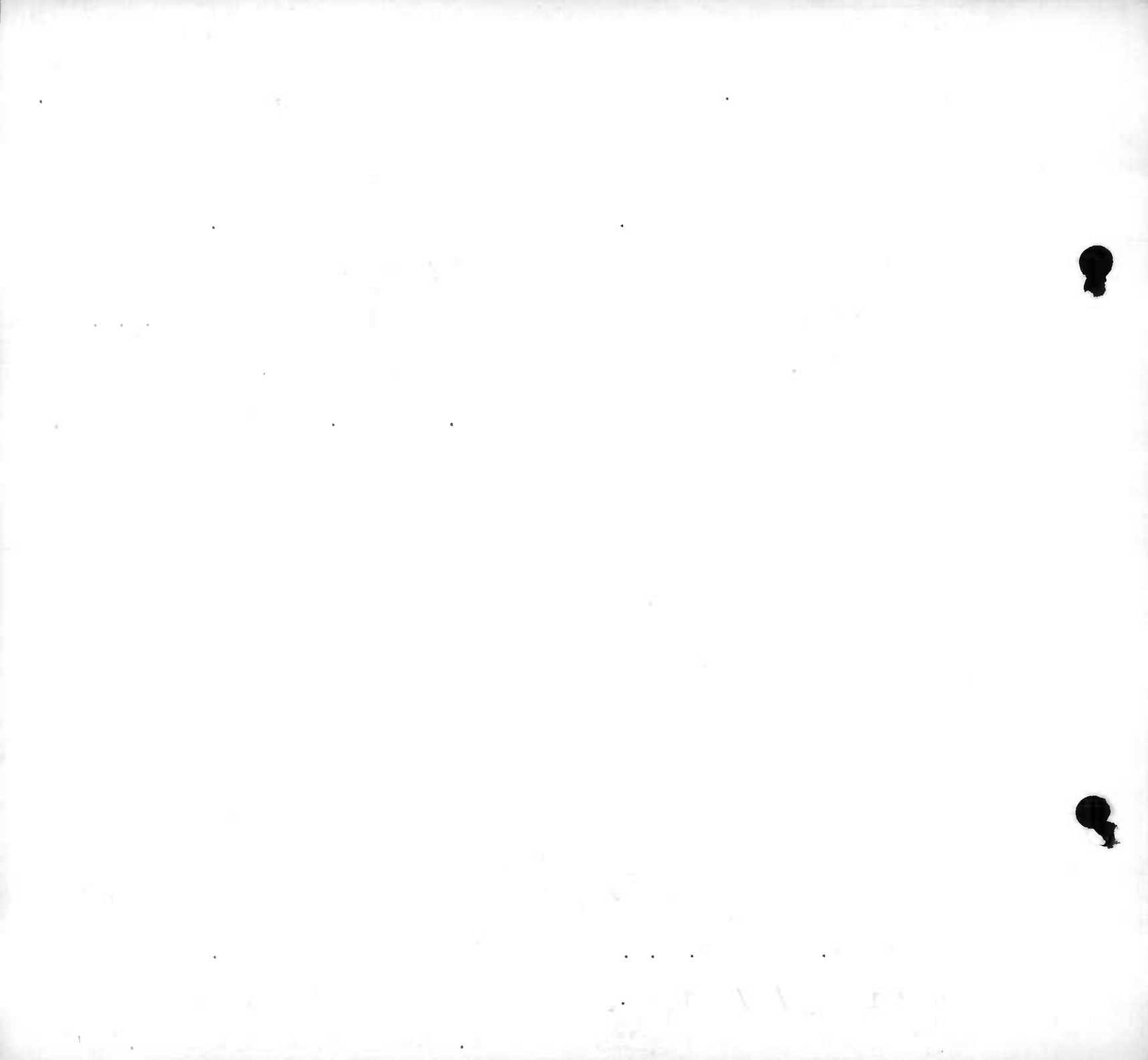
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2452 | |
|--|-------------------------|---|---------------------------------------|--|--|
| E-156 71 2452 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Charles F Eibner</i> | | 2. DATE AND HOUR OF DEATH <i>March 7 1971</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | M. 2714 | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>001132 Falls Hill Drive</i> | | A. STATE <i>Md</i> B. COUNTY | | C. CITY OR TOWN <i>Baltimore</i> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER <i>1132 Falls Hill Drive</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1 MAY 1908</i> | 9. AGE (in years last birthday) <i>62</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Presser</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing Mfg</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md</i> | |
| 13. FATHER'S NAME <i>Wenzel Eibner</i> | | 14. MOTHER'S MAIDEN NAME <i>Mithelde Tauber</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW I</i> | | 16. SOCIAL SECURITY NO. <i>212149411</i> | | 17. INFORMANT <i>Ethel M Eibner</i> | |
| 18. <i>1971</i> | | CAUSE OF DEATH | | ADDRESS <i>SAME</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.] | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of the Liver</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/21</i> 19 <i>70</i> to <i>3/7</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>3-4</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Reuben Hoffman</i> | | 23B. DATE SIGNED <i>3-10-71</i> | | 23C. PHYSICIAN'S NAME (Type) <i>REUBEN HOFFMAN, M.D.</i> | |
| 23D. ADDRESS <i>846 W. 36 St. Baltimore, Md. 21211</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>10 MAR 71</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley Mem</i> | | 24D. LOCATION (City, town, or county) (State) <i>Cockeysville Bz H Co Md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 12 1971</i> | |
| 25B. NAME OF REGISTRAR <i>Reuben Hoffman</i> | | 25C. FUNERAL DIRECTOR <i>Burger Funeral Home</i> | | ADDRESS <i>Baltimore Md</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2453 | |
|--|--|---|---|---|--|
| <p>B-620 71 2453</p> <p>BIRTH NO.</p> | | <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> | | | |
| <p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;"><u>Ida L. Gorrick</u></p> | | | <p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;"><u>March 7, 1971</u> <u>1:30 P.M.</u></p> | | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> | | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>2102</u></p> | | |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION</p> <p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>1239 Washington Blvd.</u></p> | | | <p>C. CITY OR TOWN</p> <p><u>Baltimore</u></p> | | <p>D. INSIDE CITY LIMITS?</p> <p>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> |
| <p>5. SEX <u>Female</u> 6. RACE <u>White</u></p> | | | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2/5/1879</u></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>92</u></p> | | <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Housewife</u></p> |
| <p>10B. KIND OF BUSINESS OR INDUSTRY</p> | | | <p>11. BIRTHPLACE (State or foreign country)</p> <p><u>Maryland</u></p> | | <p>12. CITIZEN OF WHAT COUNTRY?</p> <p><u>U.S.A.</u></p> |
| <p>13. FATHER'S NAME</p> <p><u>Edward J. Hickman</u></p> | | | <p>14. MOTHER'S MAIDEN NAME</p> <p><u>Josephine Barrick Barrick</u></p> | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>NO</u></p> | | | <p>16. SOCIAL SECURITY NO.</p> | | <p>17. INFORMANT</p> <p><u>Mrs. Myrtle J. Wharry 308 Galan Rd.</u></p> |
| <p>18. <u>4387 I</u></p> | | | <p>CAUSE OF DEATH</p> | | |
| <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> | | | <p>(A) IMMEDIATE CAUSE</p> <p><u>Cerebral Thrombosis</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>3 day</u></p> |
| <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | | <p>(B) <u>Cerebral Arteriosclerosis</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> | | <p><u>5 years</u></p> |
| <p>(C) _____</p> | | | <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | |
| <p>19A. DATE OF OPERATION</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No)</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> | | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>1-22</u> 19 <u>49</u> to <u>3/7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/6</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE</p> <p style="text-align: center;"><u>John P. Urlock Jr. M.D.</u></p> | | | | | <p>23B. DATE SIGNED</p> <p style="text-align: center;"><u>3/10/71</u></p> |
| <p>23C. PHYSICIAN'S NAME (Type)</p> <p><u>John P. Urlock Jr. M.D.</u></p> | | | <p>23D. ADDRESS</p> <p><u>1227 Washington Blvd.</u></p> | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> | | <p>24B. DATE</p> | | <p>24C. NAME of CEMETERY or CREMATORY</p> | |
| <p><u>Burial</u></p> | | <p><u>3/11/1971</u></p> | | <p><u>Mt. Olivet</u></p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT.</p> | | <p>25B. NAME OF REGISTRAR</p> | | <p>25C. FUNERAL DIRECTOR</p> | |
| <p><u>MAR 12 1971</u></p> | | <p><u>John P. Urlock Jr.</u></p> | | <p><u>Truman Schwab 5151 Balto. Nat'l Pik</u></p> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. [REDACTED] 2454 | |
|--|--|---|--|--|---|
| M-500 | | 71 2454 | | 71 2454 | |
| 1. NAME OF DECEASED (Type or Print) HERMAN MENNE JR. | | | 2. DATE AND HOUR OF DEATH 3/9/71 4:00 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HARBOR VIEW NURSING CENTER | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2003 | | |
| 5. SEX M | | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDENER | | 10B. KIND OF BUSINESS OR INDUSTRY Self-Emp. Retired | | 8. DATE OF BIRTH 4/24/88 | |
| 12. FATHER'S NAME HERMAN MENNE SR. | | 14. MOTHER'S MAIDEN NAME Babett MUNCER | | 9. AGE (In years last birthday) 82 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-10-3825 | | 17. INFORMANT Mary A. Menne | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 4/24/88 17-25-0.9 | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V. Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 2 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/25 19 69 to 3/9 19 71 that (I) (we) last saw the deceased alive on 1/30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph S. Blum MD | | | | 23B. DATE SIGNED 3/10/71 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD | | | | 23D. ADDRESS 1115 N. CALVERT ST | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/12/71 | | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Woodlawn, Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | | |
| 25B. NAME OF REGISTRAR Stanbury Funeral Home | | 25C. FUNERAL DIRECTOR 6411 Windsor Mill | | | |



FUNERAL DIRECTOR: IMPORTANT

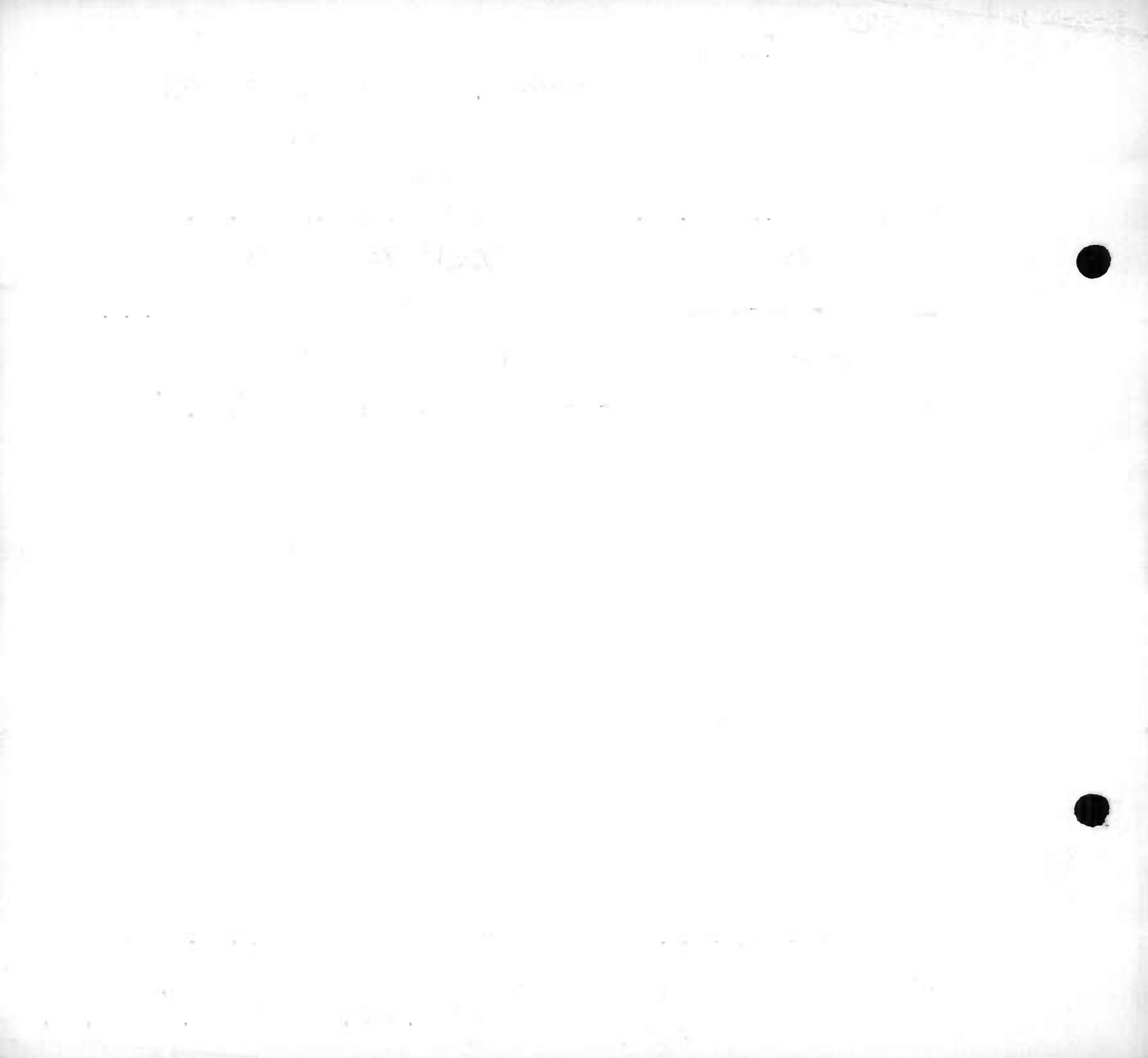
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | REG. NO. [REDACTED] |
|---|----------------------------|---|---|---|--|---|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>SANDERS, ANDREW</u> | | 2. DATE AND HOUR OF DEATH <u>3/8/71</u> <u>3:15 PM</u> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 MOH</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore city</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2033 cliffwood. ave.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>11/10/1914</u> | 9. AGE (In years last birthday) <u>66</u> | 10. Under 1 Yr. <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>NE</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | |
| 13. FATHER'S NAME <u>Ed Sanders</u> | | | 14. MOTHER'S MAIDEN NAME <u>Lula</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>217-12-9194</u> | | 17. INFORMANT <u>Face sheet</u> ADDRESS <u>-</u> | | |
| 18. CAUSE OF DEATH | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Metastatic Ca -</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Bronchiogenic Ca -</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | | | |
| II | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/8/71</u> to <u>3/8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/8/71</u> and that (in my) (our) opinion death occurred on the date <u>3/8</u> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE <u>Manojwala</u> | | | | 23B. DATE SIGNED <u>3/8/71</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>MANE JWALA</u> | | | | 23D. ADDRESS <u>MOH</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-13-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u> | | |
| 24D. LOCATION (City, town, or county) (State) <u>Arbutus Maryland</u> | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1971</u> | | 25B. NAME OF REGISTRAR <u>Chas. E. [illegible]</u> | | 25C. FUNERAL DIRECTOR <u>Randolph W. [illegible]</u> | | |
| ADDRESS <u>2431 E. Oliver St.</u> | | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2456 | |
|---|------------------|--|----------------------------------|---|--|
| BIRTH NO. 1-520 | | 71 2456 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MILTON G. LONG | | 2. DATE AND HOUR OF DEATH March 10 th 1971 1:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Ave., Balto. Md. 21224 | | A. STATE B. COUNTY Maryland Baltimore 5300 | | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Baltimore City Hospital | | C. CITY OR TOWN Dundalk | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 8226 Beltzer Rd., Balto. Md. 21222 | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 19 1903 | 9. AGE (in years last birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor - Self-employed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME George Long | | 14. MOTHER'S MAIDEN NAME Amanda Schrauer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [if yes, give war or dates of service] No | | 16. SOCIAL SECURITY NO. 213-09-3573 | | 17. INFORMANT BCH Records: Baltimore, Md. 21224 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (B) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: Disease (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 1/2 Hours Years. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 9 1971 to March 10 1971 that (I) (we) last saw the deceased alive on March 10 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James K. Yeung, M.D. | | 23B. DATE SIGNED March 10 1971 | | | |
| 23C. PHYSICIAN'S NAME (Type) James K. Yeung, M.D. | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., Balto. Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/71 | | 24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR John J. Duda, M.D. | | 25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | |



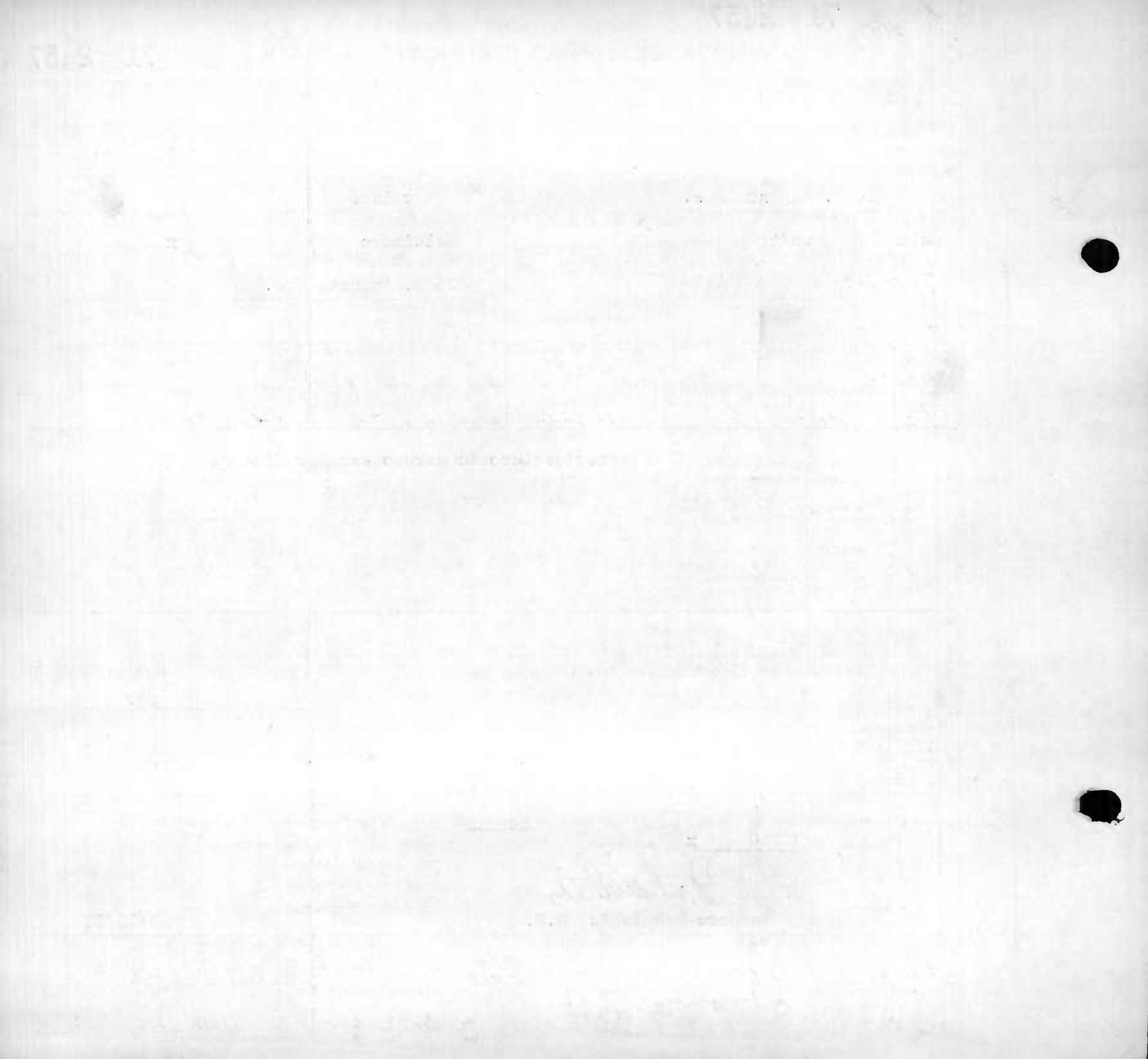
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 2457

BIRTH NO.

| | | | |
|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) NORMAN VEIT | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 426 S. Augusta Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 3 9 1971 1:25 p.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 8/15/30 | | 10. AGE (In years lost birthday) 41 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 14B. KIND OF BUSINESS OR INDUSTRY Construction | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1948-1953 | | 17. SOCIAL SECURITY NO. 214-26-4099 | |
| 15. MOTHER'S MAIDEN NAME Marion Bigley | | 18. INFORMANT Marion Veit | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 3/10/71 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/12/71 | 24C. NAME OF CEMETERY or CREMATORY Louisa Park Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | 25B. NAME OF REGISTRAR Isidore Mihalakis | 25C. FUNERAL DIRECTOR Amador & Son | ADDRESS 1828 Sulphur Sp. Rd. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2458 | |
|--|---------|--|---|--|---|
| <div style="display: flex; justify-content: space-between;"> B-220 71 2458 71 2458 </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ANNA M BOCEK | | 3/9/71 3:05 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL 43 | | | A. STATE Md. | | |
| | | | B. COUNTY 2643 | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 2905 Edison Highway, Balto., Md. 21213 | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days |
| F | W | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 3-30-95 | 75 | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| HOUSEWIFE | | | Balto., Md. | | U.S. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT (niece) |
| no | | | | | Mrs. Dorothy Kehoe, 2904 Edison Highway |
| 18. 203X1 | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | Multiple Myeloma | | |
| ANTECEDENT CAUSES | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-5-71 to 3/9/71 | | | | | |
| that (I) (we) last saw the deceased alive on 3/9/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| AYE NGWE M.D. DEGREE | | | | 3/9/71 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| AYE NGWE M.D. DEGREE | | | | SOUTH BALTIMORE GENERAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| burial | | 3/12/71 | | Holy Redeemer | |
| | | | | Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 12 1971 | | Schimunek Funeral Home, Inc., 3331 Brehms Lane, Balto., Md. 21213 | | | |

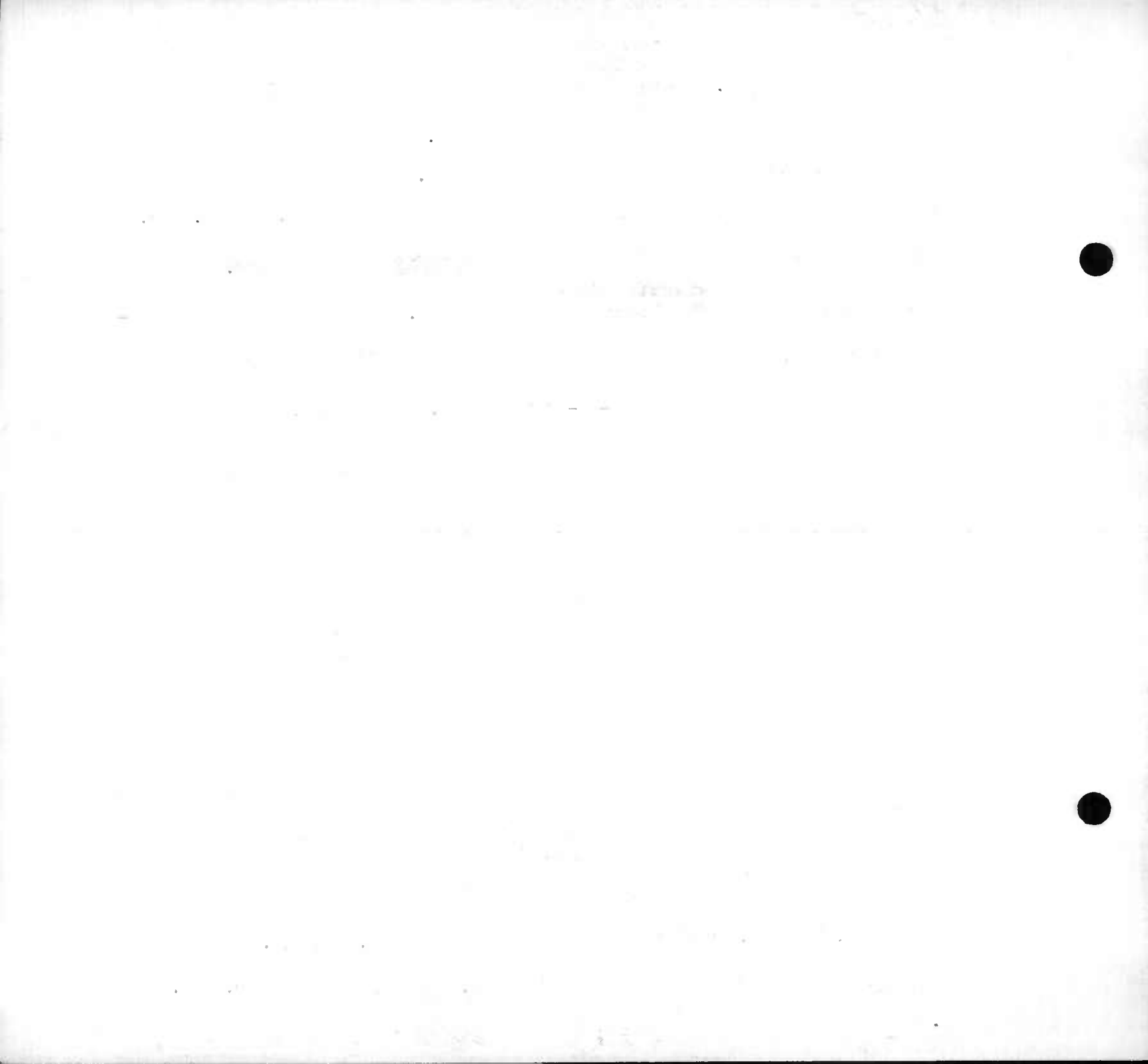
1943. 10. 1.

21

FUNERAL DIRECTOR: IMPORTANT

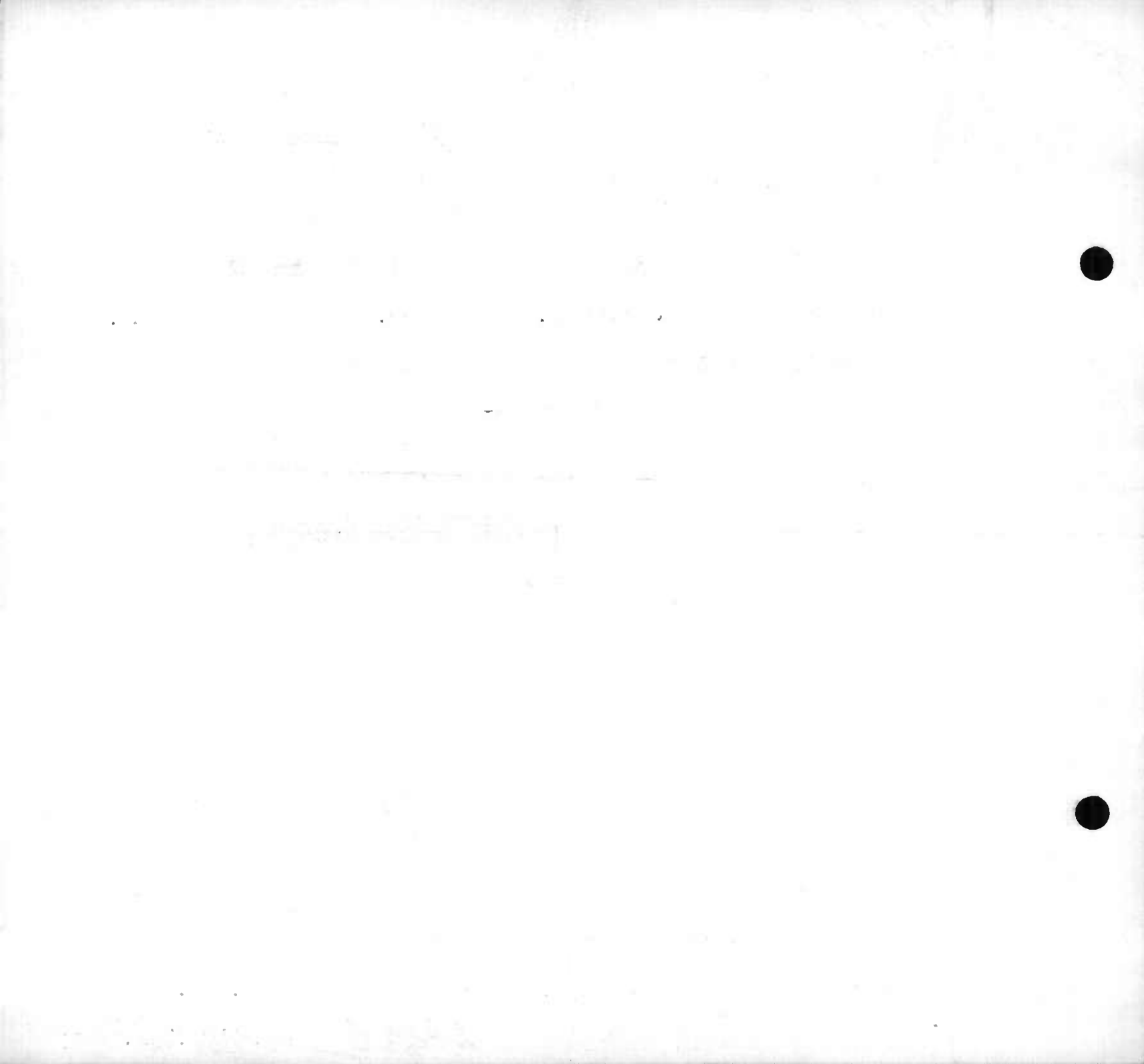
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------------------|---|--|--|--|---|--|
| 6-655 71 2459 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 71 2459 | |
| 1. NAME OF DECEASED (Type or Print) Aubrey L. German | | | | 2. DATE AND HOUR OF DEATH 3/8/71 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto. 5300 | | | |
| | | | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 6654 Loch Hill Rd., Balto., Md. 21239 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/12/13 | | 9. AGE (In years last birthday) 57 yrs. | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant | | 10B. KIND OF BUSINESS OR INDUSTRY Langrall Muir & Noppinger | | 11. BIRTHPLACE (State or foreign country) Balto. | | 12. CITIZEN OF WHAT COUNTRY? - | |
| 13. FATHER'S NAME George A. German | | | | 14. MOTHER'S MAIDEN NAME Lillian Gaither | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 218-01-6271 | | 17. INFORMANT Mrs. Anne German, | | ADDRESS same address | |
| 18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarct ASCVD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 yr 15 yr | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Rheumatic heart dis. - mitral | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis | | 25 yr | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1959 19 to March 8 19 71 that (I) (we) last saw the deceased alive on Feb 18 19 71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE D.A. Oursler, MD | | | | 23B. DATE SIGNED March 9/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. David A. Oursler | | | | 23D. ADDRESS 3100 St. Paul St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 3/12/71 | | 24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Gardens | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR Robert J. ... | | 25C. FUNERAL DIRECTOR Blanchard, F.R. | | ADDRESS 833/1515 4ms Lb. 13041 mod | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

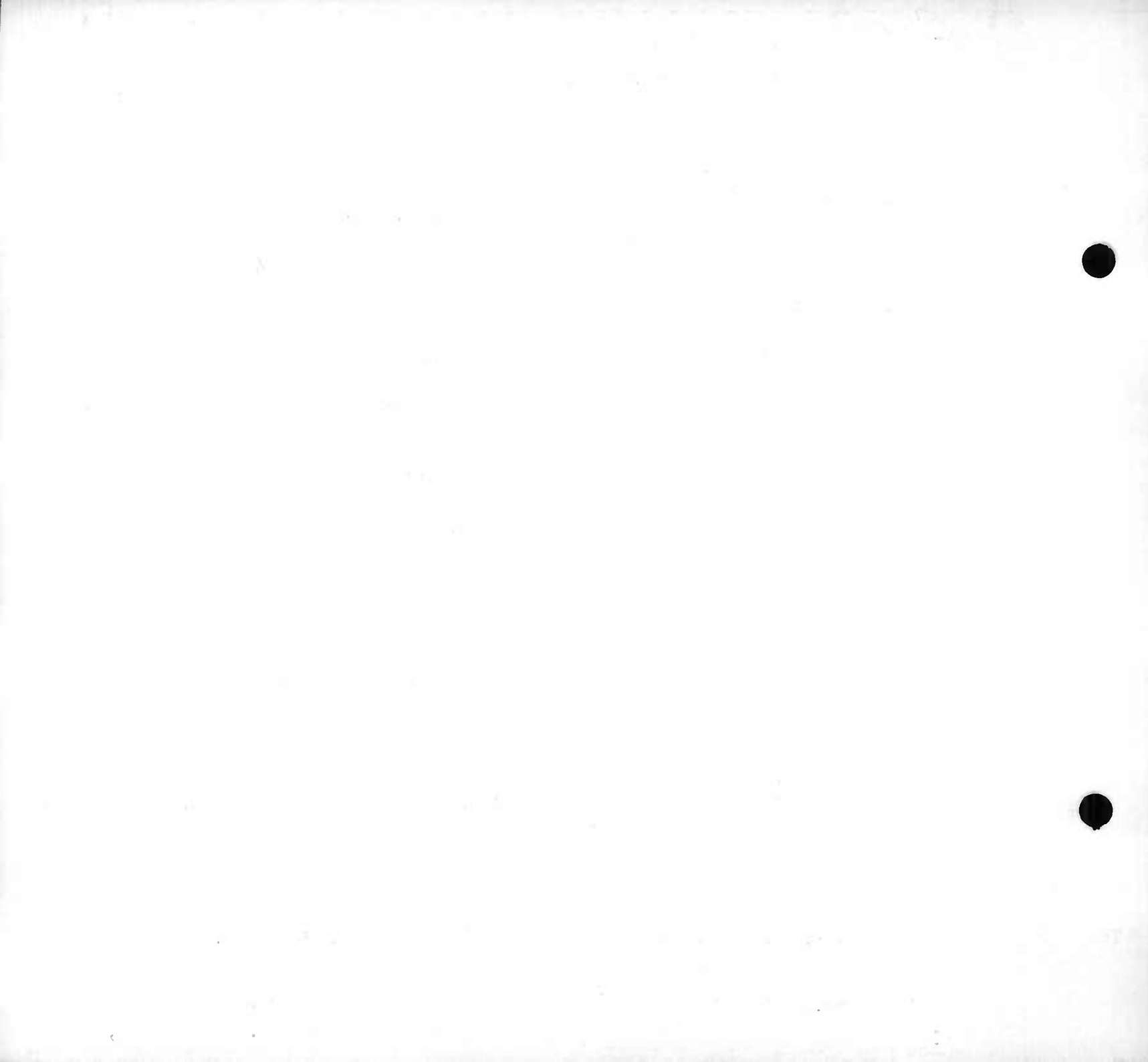
VS 150-REV. 1/1/6B



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2461 | |
|--|---------------------|---|--|---|--|
| BIRTH NO. C-163 | | 71 2461 | | | |
| 1. NAME OF DECEASED (Type or Print) Henrietta Ernestine Cabaret | | | 2. DATE AND HOUR OF DEATH Mar. 10, 1971 7:45 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE NY B. COUNTY V-29 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 2x3100 Wyman Parkway | | | C. CITY OR TOWN Riverhead | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 860 W. Main Street | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/4/06 | 9. AGE (in years last birthday) 64 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 11. BIRTHPLACE (State or foreign country) NY | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Gaston Nevejans | | | 14. MOTHER'S MAIDEN NAME Julia Denys | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No | | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT Records- US PHS Hospital, Balto, Md. |
| 18. 203X1 CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage | | | 1 day | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Multiple myeloma | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Years | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 203X1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Jan. 11 1971 to Mar. 10 1971 that (1) (we) lost saw the deceased alive on Mar. 10 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Samuel P. Ward, M.D. | | | | 23B. DATE SIGNED 3/10/71 | |
| 23C. PHYSICIAN'S NAME (Type) Samuel P. Ward, Surgeon (R) | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/71 | | 24C. NAME of CEMETERY or CREMATORY Riverhead | |
| 24D. LOCATION Riverhead, New York | | 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | | |
| 25B. NAME OF REGISTRAR Leonard J. Buck Inc. | | 25C. FUNERAL DIRECTOR ADDRESS Baltimore, Md | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> G-320 71 2462 </div> | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2462 | |
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) MRS. CARRIE B. GOETZKE | | 2. DATE AND HOUR OF DEATH 3-11-71 12⁴² a.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Keswick Home for Incurables of Balto. City | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Balto. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 700 W. 40th Street | | | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/3/1883 | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) /?? Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY /?? | | 11. BIRTHPLACE (State or foreign country) BALTO., MD. 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JAMES CHRISTHILF | | | 14. MOTHER'S MAIDEN NAME MARY CHASE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 101E1-212-32-5092 | | 17. INFORMANT V. Crouch R.N. ADDRESS KESWICK FILES 700 W. 40th STREET | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident (C) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 11 yrs 4 yrs | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3 Apr 19 67 to 11 MAR 19 71 that (I) (we) last saw the deceased alive on 11 MAR 19 71 and that I (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Aubrey D. Richardson, M.D. | | | | 23B. DATE SIGNED 11 MAR 1971 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS Keswick Home | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/71. | | 24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | | |
| 25B. NAME OF REGISTRAR John E. ... | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |

2513 Wentworth Rd.

Adm 4/3/67

2nd

Therapist

11/12

General Hospital

Adm 4/3/67
with medical information

11

11 Mar 67

3 Apr 67

11 Mar 67

11 Mar 1967

Dr. D. Richardson

Dr. D. Richardson, M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|---|---|--|---|--|
| BIRTH NO. S-540 | | 71 2463 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2463 | |
| 1. NAME OF DECEASED (Type or Print) GLADYS SCHAMMEL | | | | 2. DATE AND HOUR OF DEATH March 11, 1971. 13:41 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 831 | | | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 2814 Pelham Avenue | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 11, 1900. | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months | If Under 24 Hrs. Hours | If Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker. | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME ? Diacont | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 214-03-0403D | | 17. INFORMANT Mr. Philip W. Schammel, 3718 Chesmont Ave. # | | |
| 18. 4330 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis | | | CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral atherosclerosis | | | 4 months | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension | | | 5 yrs. | |
| | | | (C) Hypertension | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 29 19 70 to March 11 19 71 that (I) (we) last saw the deceased alive on March 9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Alan B. Cohen | | | | 23B. DATE SIGNED 3/11/71 | | | |
| 23C. PHYSICIAN'S NAME (Type) Alan B. Cohen MD | | | | 23D. ADDRESS Marylander Apts. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/15/71. | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR John P. ... | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

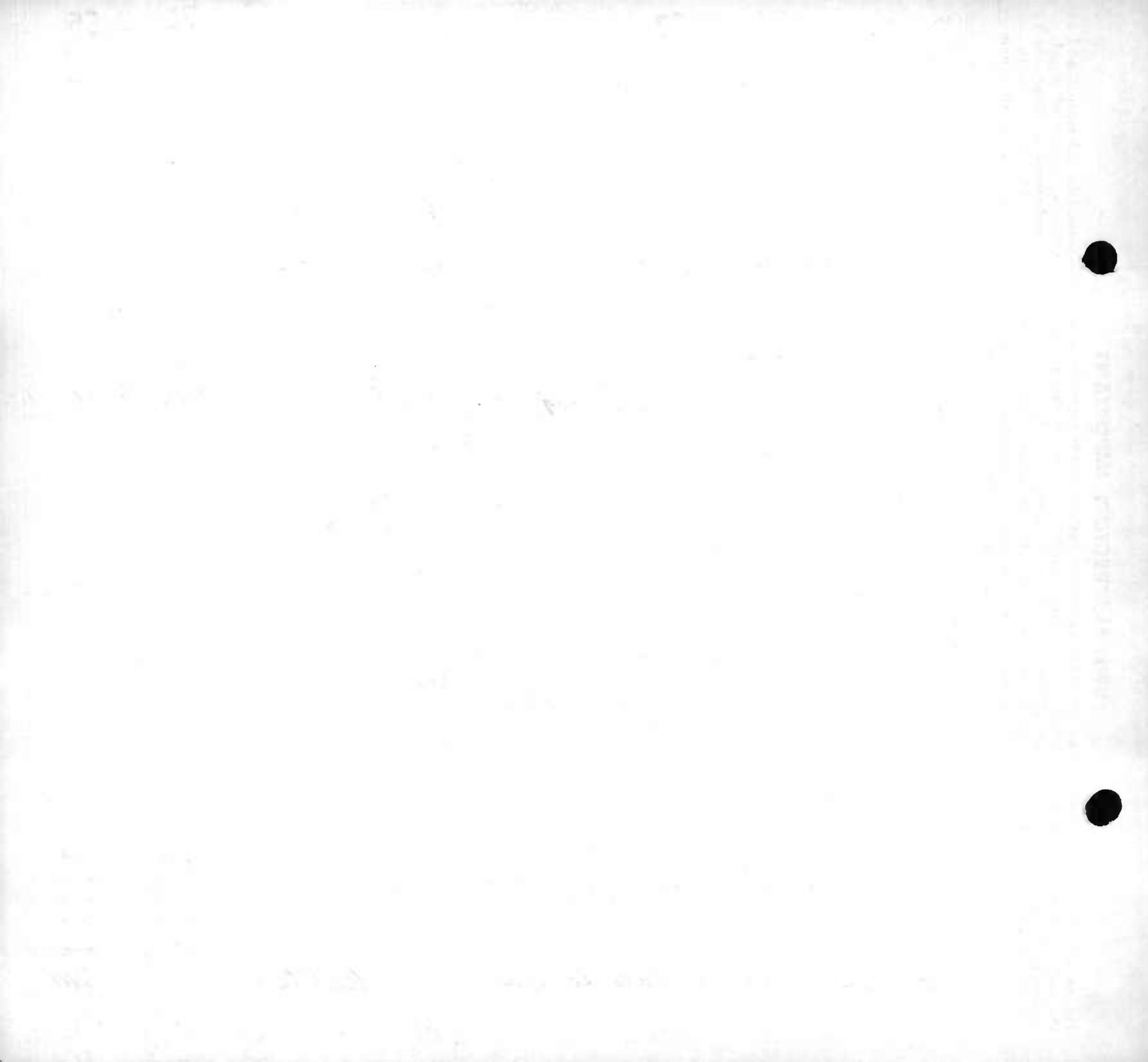
| | | | | | |
|---|-------------------------|--|------------------------------------|---|---|
| K-532 71 2464 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | 71 2464 REG. NO. | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) KENDZEJESKI, MARIE E. | | 2. DATE AND HOUR OF DEATH March 7, 1971 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 803 S. Belnord Avenue | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 803 S. Belnord Avenue | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-27-18 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Herman Spielman | | 14. MOTHER'S MAIDEN NAME Anna Stumpf | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-09-2277 | | 17. INFORMANT James Kendzejeski 803 S. Belnord Ave., Baltimore, Md. | |
| 18. 149X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Ca of pharynx & larynx (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mos | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 12/27 19 69 to 3/7 19 71 that (I) was last saw the deceased alive on 3/7 19 71 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Henry J. Houska MD | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) HENRY J. HOUSKA MD | |
| 23D. ADDRESS 333 S. EAST AVE BALTO MD | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 3-11-71 | | 24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR Robert E. J. J. J. J. | | 25C. FUNERAL DIRECTOR Nicholas T. Matthews 3021 Eastern Ave., Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

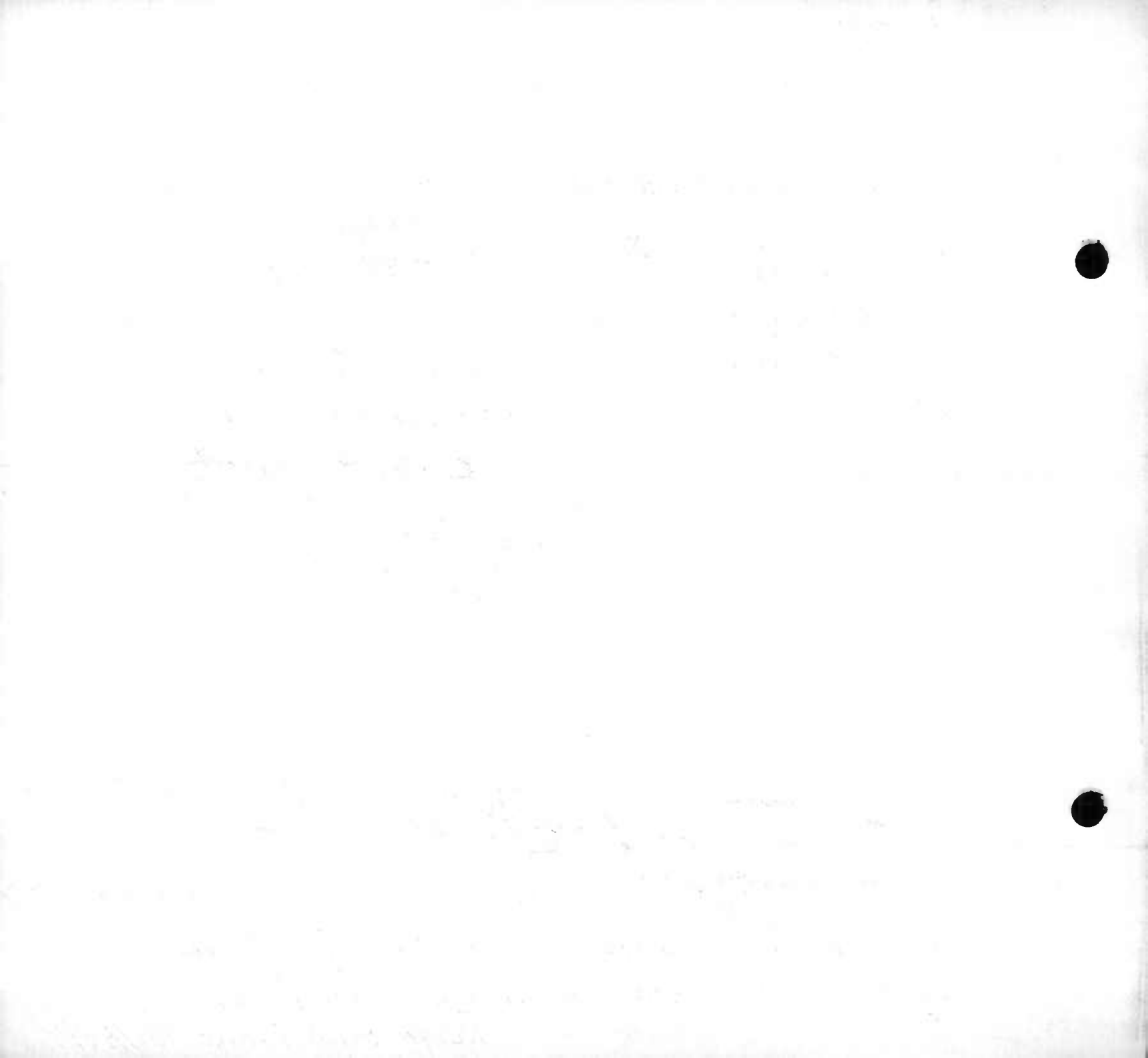
| B-454 71 2463 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 71 2465 | |
|--|-------------------------|---|---|--|--|---|---|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>ANNA BLIMLINE</u> | | | | 2. DATE AND HOUR OF DEATH <u>3/10/71</u> <u>11:55 AM</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>MERCY HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2609</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3716 FOSTER AVE.</u> | | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/12/99</u> | | 9. AGE (In years last birthday) <u>72</u> | | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>MICHAEL KRAUS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH FREUND</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>B</u> <u>216-05-4939</u> | | 17. INFORMANT <u>Mrs. Dorothy Morris</u> ADDRESS <u>3716 Foster Ave</u> | | | | |
| 18. <u>25-0-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH <u>CARDIAC ARREST</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.S.H.D</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>DIABETES MELLITUS</u> (C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from <u>3/6</u> 19 <u>71</u> to <u>3/10</u> 19 <u>71</u> that (W) (we) last saw the deceased alive on <u>3/10</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Dr. A. H. Wilkerson MD</u> | | | | | | 23B. DATE SIGNED <u>3/10/71</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. A. H. Wilkerson</u> | | | | | | 23D. ADDRESS <u>Balto Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-13-71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher MD</u> | | 25C. FUNERAL DIRECTOR <u>Hoffman Funeral Home</u> | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

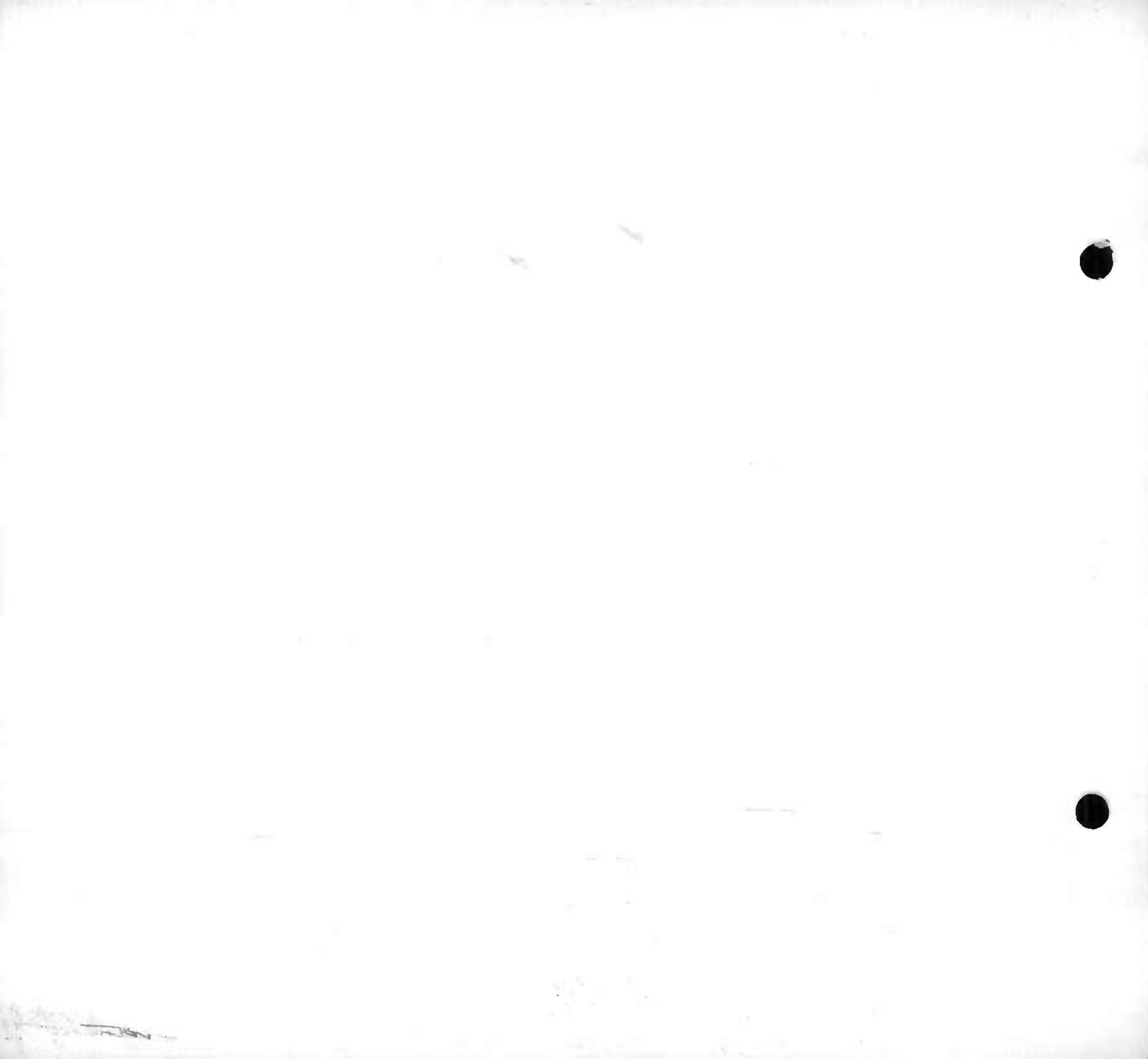
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2466</u> | |
|---|--|--|--|--|--|
| L-563 71 2466 | | BIRTH NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Leo</u> | | 2. DATE AND HOUR OF DEATH <u>March 8 1971</u> | | M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) | | A. STATE <u>MD</u> B. COUNTY <u>2765</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>4438 Clydesdale Ave</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>4438 Clydesdale Ave</u> | | 5. SEX <u>Male</u> 6. RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>3-1-97</u> | | 9. AGE (In years lost birthday) <u>74</u> | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed Roofer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Roofing</u> | | 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>John Linardi</u> | | 14. MOTHER'S MAIDEN NAME <u>Angel Cortese</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>21712 9512</u> | | 17. INFORMANT <u>Florence Linardi</u> | |
| 18. <u>412.41</u> CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | ANTECEDENT CAUSES | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from <u>June 1968</u> to <u>3-8-71</u> and that (I) (we) last saw the deceased alive on <u>Feb. 3-71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>C. E. Aronoff</u> | | 23B. DATE SIGNED <u>March 10 1971</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Dr. Carlos E. Aronoff</u> | |
| 23D. ADDRESS <u>1701 Meredene Drive</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2-12-71</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cmn</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1971</u> | |
| 25B. NAME OF REGISTRAR <u>Robert E. Nalley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Borgue Funeral Home</u> | | 25D. ADDRESS <u>Baltimore Md</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2467</u> | |
|--|--------------------------------|---|---|---|--|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>CHINOR COLLICK</u> | | 2. DATE AND HOUR OF DEATH <u>3-4-71</u> <u>6:40 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY OF MARYLAND HOSPITAL</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1302</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2211 LINDEN AVE.</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>BLACK</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>1-29-35</u> | 9. AGE (In years last birthday) <u>35</u> | If Under 1 Yr. Months <u> </u> Days <u> </u> If Under 24 Hrs. Hours <u> </u> Min. <u> </u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DYE MAKER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u> <u>DYE MAKER</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>JOSEPH COLLICK</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>ATLANTA COLEMAN</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>KRINETTA SEWARD (SISTER)</u> <u>2821 N. DENHAM CIRCLE</u> | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (A) IMMEDIATE CAUSE <u>HEPATIC COMMA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CIRRHOSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>P. HEMOTHORAX</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>SEVERAL YEARS</u> <u>1 WEEK</u> | |
| MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>4-4-</u> <u>19 71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Jaime F. Casellas M.D.</u> 23C. PHYSICIAN'S NAME (Type) <u>JAIME F. CASELLAS M.D.</u> | | 23B. DATE SIGNED <u>4-4-71</u> | | 23D. ADDRESS <u>UNIVERSITY OF MARYLAND HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/9/71</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>mt Auburn</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore City</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1971</u> | | | |
| 25B. NAME OF REGISTRAR <u>2000 378</u> | | 25C. FUNERAL DIRECTOR <u>2220 1st St. 23</u> | | ADDRESS <u>Montgomery</u> | |



C-452

71 2468

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2468

BIRTH NO.

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) WILLIAM COLLINS | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month March Day 7 Year 1971 Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (DOA) South Baltimore General Hospital | | 3. DATE PRONOUNCED DEAD Month March Day 7 Year 1971 Hour 1:55 A. M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2301 | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday) 70 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | ADDRESS | |
| 19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3/10/71 | |
| 24C. NAME OF CEMETERY or CREMATORY MT AUBURN | | 24D. LOCATION (City, town, or county) (State) BALTI Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR ROBERT BROWN | |
| 25C. FUNERAL DIRECTOR ADDRESS | | 25D. DATE SIGNED March 7, 1971 | |

1. Name of patient: _____
2. Date of birth: _____
3. Sex: _____
4. Race: _____
5. Address: _____
6. City: _____
7. State: _____
8. Zip: _____
9. Date of admission: _____
10. Date of discharge: _____
11. Date of death: _____
12. Cause of death: _____
13. Place of death: _____
14. Date of autopsy: _____
15. Name of pathologist: _____
16. Name of attending physician: _____
17. Name of hospital: _____
18. Name of city: _____
19. Name of state: _____
20. Name of zip: _____

1. Name of patient: _____
2. Date of birth: _____
3. Sex: _____
4. Race: _____
5. Address: _____
6. City: _____
7. State: _____
8. Zip: _____
9. Date of admission: _____
10. Date of discharge: _____
11. Date of death: _____
12. Cause of death: _____
13. Place of death: _____
14. Date of autopsy: _____
15. Name of pathologist: _____
16. Name of attending physician: _____
17. Name of hospital: _____
18. Name of city: _____
19. Name of state: _____
20. Name of zip: _____

1. Name of patient: _____
2. Date of birth: _____
3. Sex: _____
4. Race: _____
5. Address: _____
6. City: _____
7. State: _____
8. Zip: _____
9. Date of admission: _____
10. Date of discharge: _____
11. Date of death: _____
12. Cause of death: _____
13. Place of death: _____
14. Date of autopsy: _____
15. Name of pathologist: _____
16. Name of attending physician: _____
17. Name of hospital: _____
18. Name of city: _____
19. Name of state: _____
20. Name of zip: _____

ACADEMIC RECORD

NAME OF STUDENT

1. Name of patient: _____
2. Date of birth: _____
3. Sex: _____
4. Race: _____
5. Address: _____
6. City: _____
7. State: _____
8. Zip: _____
9. Date of admission: _____
10. Date of discharge: _____
11. Date of death: _____
12. Cause of death: _____
13. Place of death: _____
14. Date of autopsy: _____
15. Name of pathologist: _____
16. Name of attending physician: _____
17. Name of hospital: _____
18. Name of city: _____
19. Name of state: _____
20. Name of zip: _____

1. Name of patient: _____
2. Date of birth: _____
3. Sex: _____
4. Race: _____
5. Address: _____
6. City: _____
7. State: _____
8. Zip: _____
9. Date of admission: _____
10. Date of discharge: _____
11. Date of death: _____
12. Cause of death: _____
13. Place of death: _____
14. Date of autopsy: _____
15. Name of pathologist: _____
16. Name of attending physician: _____
17. Name of hospital: _____
18. Name of city: _____
19. Name of state: _____
20. Name of zip: _____

1. Name of patient: _____
2. Date of birth: _____
3. Sex: _____
4. Race: _____
5. Address: _____
6. City: _____
7. State: _____
8. Zip: _____
9. Date of admission: _____
10. Date of discharge: _____
11. Date of death: _____
12. Cause of death: _____
13. Place of death: _____
14. Date of autopsy: _____
15. Name of pathologist: _____
16. Name of attending physician: _____
17. Name of hospital: _____
18. Name of city: _____
19. Name of state: _____
20. Name of zip: _____

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2469 | |
|--|------------------|---|-----------------------------------|---|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) BABY GIRL JOHNSON | | 2. DATE AND HOUR OF DEATH 7 MARCH 71 1842 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) U.O.F MD. HOSPITAL BALTO MD. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2552 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 508 BRIDGEVIEW RD | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 22 Feb-71 | 9. AGE (in years last birthday) 0 13 | 10. Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MD | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME LARRY JONES | | | |
| 14. MOTHER'S MAIDEN NAME SHEILA JOHNSON | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT CHART ADDRESS — | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HYALINE MEMBRANE DISEASE | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PREMATURITY | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 DAYS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. — NONE — | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). — NONE — | | | | | |
| 19A. DATE OF OPERATION 0 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (this hospital) attended the deceased from 22 Feb 1971 to 7 March 1971 that (we) last saw the deceased alive on 7 March 1971 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John V. Payne MD | | 23B. DATE SIGNED 7 March 71 | | 23C. PHYSICIAN'S NAME (Type) JOHN V. PAYNE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 319, 71 | | 24B. DATE ML AUBUR | | 24C. NAME of CEMETERY or CREMATORY BALTI. MD | |
| 24D. LOCATION (City, town, or county) (State) BALTI. MD | | 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR. ROLAND A BROWN | |
| 25C. FUNERAL DIRECTOR ADDRESS 123 W MONTGOMERY | | | | | |

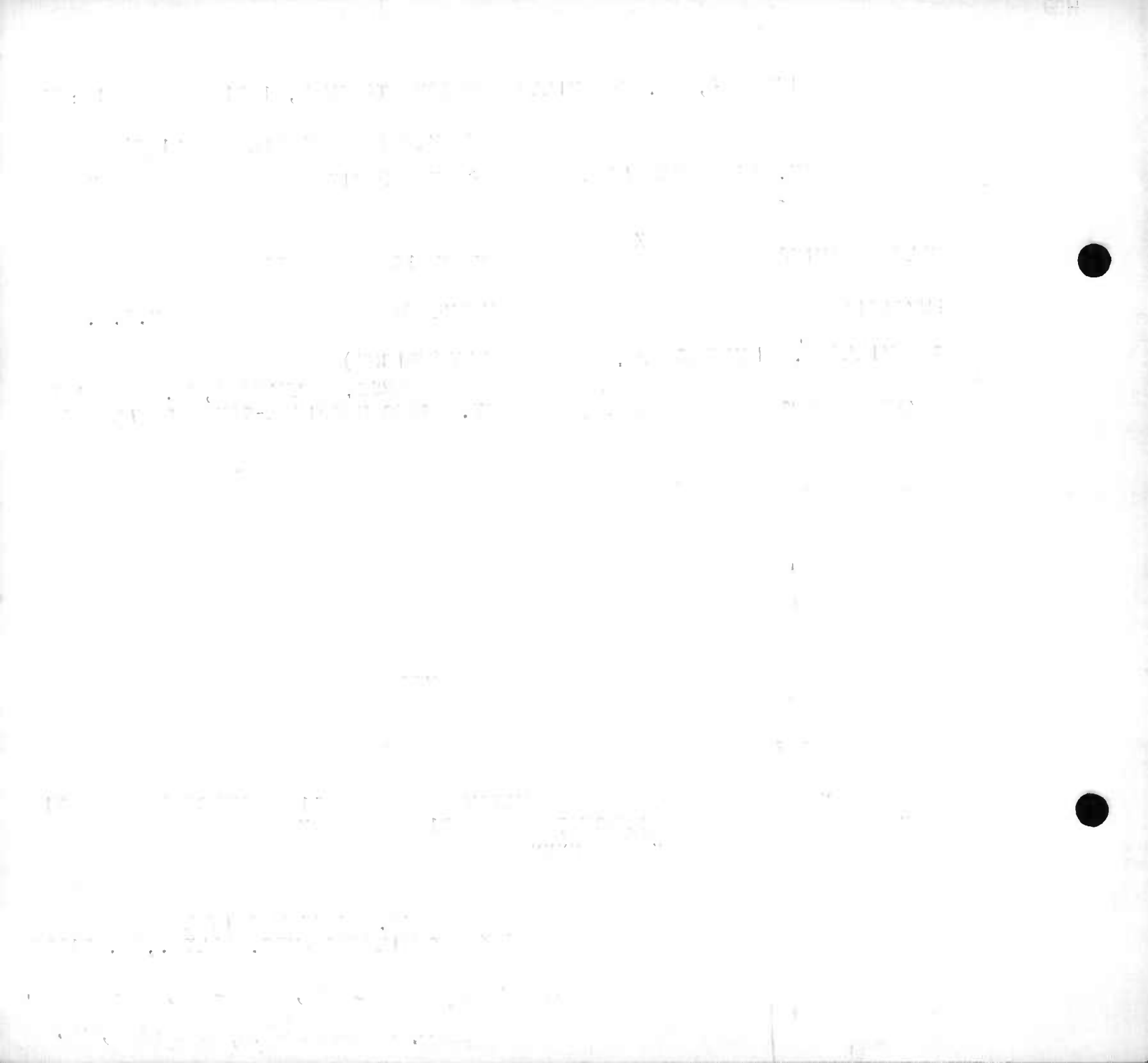


medical examiner released to hospital

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| HBD | | 71 2470 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2470 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH X | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| RICHARDS, DR. GRANVILLE HAMPTON | | | | MARCH 7, 1971 10:05AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL | | | | A. STATE MARYLAND B. COUNTY CECIL 21904 5700 | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN PORT DEPOSIT D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| E. STREET AND NUMBER | | | | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 07 02 15 | |
| | | | | | | 9. AGE (in years last birthday) 55 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME H. GRANVILLE M. RICHARDS Sr. | | | | 14. MOTHER'S MAIDEN NAME EMMA (WRIGHT) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW2 | | | | 16. SOCIAL SECURITY NO. 160-16-2543 | | | |
| 17. INFORMANT AVES. BALTIMORE, MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Basilar Artery Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from MARCH 6 1971 to MARCH 7 1971 that (X) (we) last saw the deceased alive on MARCH 7 1971 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Hermergo Jr. J. Sid B. | | | | 23B. DATE SIGNED 3-7-71 | | 23C. PHYSICIAN'S NAME (Type) DEGREE | |
| 23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229 | | | | 23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/1971 | | 24C. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery | | 24D. LOCATION (City, town, or county) (State) Cecily, Maryland. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR J. Sid B. | | 25C. FUNERAL DIRECTOR Lee T. Patterson | | ADDRESS on, Perryville, Md. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JEAN LIPSITZ

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 2140 E. Baltimore St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

P.M.

3

9

1971

7:55 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

003

6. SEX

female

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

UNKNOWN

10. AGE (In years
lost birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2140 E. Baltimore St.

11. BIRTHPLACE (State or foreign country)

UNKNOWN

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN -

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

212-42-4413 BOB GARCIA

18. INFORMANT

ADDRESS

1935 E. BALTO. ST.

19. 412.4

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/10/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

3/15/71

24C. NAME of CEMETERY or CREMATORY

CEDER HALL CEM.

24D. LOCATION (City, town, or county)

GLEN BURNIE

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT

MAR 12 1971

25B. NAME OF REGISTRAR

Isidore Mihalakis, M.D.

25C. FUNERAL DIRECTOR

JOHN WEBER & SONS

ADDRESS

401 S. CHESTER ST.

10-21

WALFLEY

COOPER

WILEY

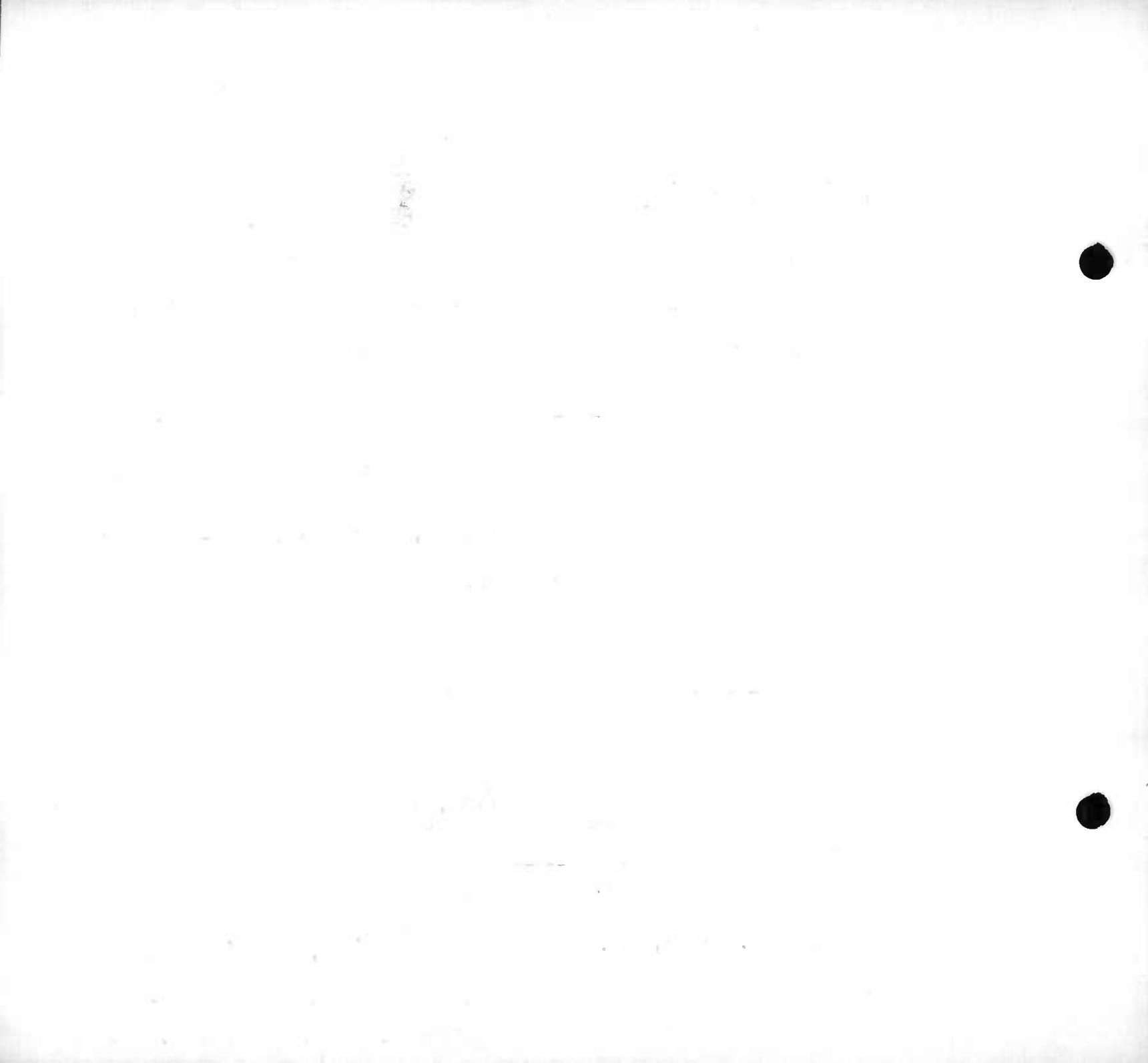
COOPER

COOPER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 71 2472 | |
|--|-------------------------|---|---|--|--|
| D-220 71 2472 | | | | | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Andrew Daskiewicz</u> | | | | 2. DATE AND HOUR OF DEATH <u>March 11, 1971</u> <u>4:00 A</u> ^{M.} | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>105</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>105 S. Chester St.</u> <u>Baltimore, 21231 Md.</u> | | | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>105 S. Chester St.</u> | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/10 1889</u> | 9. AGE (In years last birthday) <u>81</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>-----</u> | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | |
| 13. FATHER'S NAME <u>Maciej Daskiewicz</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>220-30-7421</u> | | 17. INFORMANT <u>Maria Daskiewicz</u> |
| | | | ADDRESS <u>105 S. Chester</u> | | |
| 18. <u>412.21</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic, Hypertensive, Cardio-</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Vascular Disease</u> (C) | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>March 1965</u> <u>6/19/61</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-----</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 19, 1961</u> 19 <u>71</u> to <u>March 5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>March 5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Joseph F. Drenka</u> DEGREE | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>Joseph F. Drenka, M.D.</u> DEGREE | | | | 23D. ADDRESS <u>209 S. Chester St.</u> <u>Baltimore, Maryland 21231</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>3/13/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Holy Rosary Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Dundalk Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1971</u> | | 25B. NAME OF REGISTRAR <u>John E. Weber</u> | | 25C. FUNERAL DIRECTOR <u>John M. Weber</u> | |
| | | | | ADDRESS <u>401 S. Chester</u> | |



M-245 71 2473

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2473

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED <u>SETH</u> (Type or Print) <u>McLamb</u> | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <u>3</u> Day <u>8</u> Year <u>71</u> Estimated <input type="checkbox"/> Hour <u>7:25 a.</u> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> 1111 E. Baltimore Street | | 3. DATE PRONOUNCED DEAD Month <u>3</u> Day <u>8</u> Year <u>71</u> Hour <u>7:25 a.</u> M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>302</u> | | C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX <u>male</u> | 7. RACE <u>White</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH <u>8/11/17</u> | 10. AGE (In years lost birthday) <u>55</u> | E. STREET AND NUMBER <u>1111 E. Baltimore Street</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Cager McLamb</u> | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ | |
| 15. MOTHER'S MAIDEN NAME <u>Hattie Watts</u> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 17. SOCIAL SECURITY NO. <u>237-20-6638</u> | | 18. INFORMANT <u>Jossie Kallas</u> ADDRESS <u>616 S. Quail St.</u> | |
| 19. <u>783.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary hemorrhage</u> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | |
| 20A. DATE OF OPERATION <u>2</u> | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | |
| 21. AUTOPSY? (Yes or No) <u>yes</u> | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? _____ | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? _____ | | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE <u>Russell S. Fisher, M.D.</u> EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED <u>3/8/71</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 24B. DATE <u>3/12/71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>St. Stanislaus Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Dundalk, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1971</u> | |
| 25B. NAME OF REGISTRAR <u>John M. Weber</u> | | 25C. FUNERAL DIRECTOR <u>401 S. Chester</u> | |

ST-2 127

1000

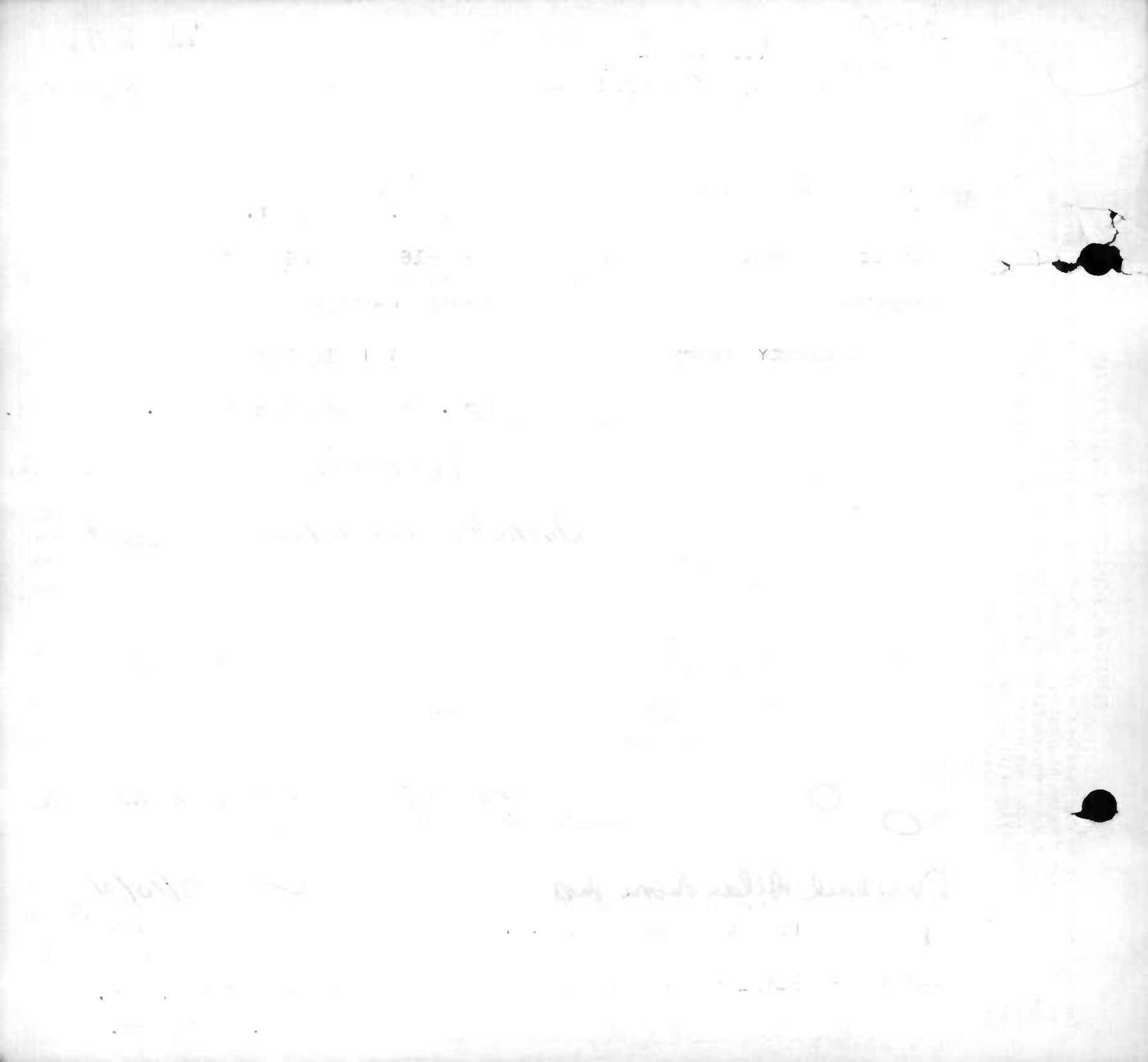
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|---|------------------------------------|---|---|---|--|--|
| J-525 71 2474 CERTIFICATE OF DEATH | | | | | REG. NO. 71 2474 | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Johnson, Mattie L.</u> | | | | | 2. DATE AND HOUR OF DEATH <u>3/10/71</u> <u>2:09 P.M.</u> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>807</u> | | | | |
| | | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER <u>1311 N. CHAPEL ST.</u> | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-10-16</u> | 9. AGE (In years last birthday) <u>54</u> | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13. FATHER'S NAME <u>JOHN KISSEY Westry</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>MATTIE Taylor</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Mrs. Madeline Lowry 2124 E. Biddle St.</u> | | | |
| 18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>uremia</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>72 months</u> | |
| | | | | | (B) <u>diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: <u>unk.</u> | | | | |
| | | | | | (C) _____ | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) this hospital attended the deceased from <u>March 1</u> 19 <u>71</u> to <u>March 10</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>March 10</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Michael Allen Moore M.D.</u> | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>3/10/71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>1</u> <u>MICHAEL ALLEN MOORE M.D.</u> | | | | | 23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>3-15-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Mt Calvary Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Cty., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1971</u> | | | 25B. NAME OF REGISTRAR <u>Robert J. Fisher</u> | | | 25C. FUNERAL DIRECTOR <u>Wm C. March</u> ADDRESS <u>928 E. North Ave.</u> | | | |



P-400

71 2475

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2475

BIRTH NO.

REG. NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) E. CLARENCE POWELL | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 3 10 1971 1:57 a.m. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 907 | |
| 9. DATE OF BIRTH 7-18-44 | | 10. AGE (In years last birthday) 26 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME James H. Powell | | 14. STREET AND NUMBER 1547 Homestead St. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME Alice C. Veney | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS Mrs. Alice Winston 1547 Homestead St. | |
| 19. CAUSE OF DEATH 5710 I Fatty metamorphosis of liver | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED 3/10/71 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-15-71 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 Robert E. Taylor, M.D. | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR Wm C March | | ADDRESS 928 E. North Ave. | |

1 2 7 1 0 0 0 2 4 7 1

2-10-42

Maryland

Laborer

James E. Howell

Alice D. Howell

Mrs. Alice Winston 1847

Bellevue, Md.

at Andrew Company

2-10-42

Original

Mr. C. Smith 202 N. 10th St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 71 2476 | | CERTIFICATE OF DEATH | | REG. NO. 71 2476 | |
|--|-------------------------|---|--------------------------------------|---|----------------------------|---|-----------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) Joseph NOVAK | | | | 2. DATE AND HOUR OF DEATH 3-9-71 16:35 A.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 Mercy Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY 104 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER 820 S. MILTON AVE | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-22-1903 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAPTAIN | | | | 10B. KIND OF BUSINESS OR INDUSTRY BALTO. TOWING | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MICHAEL NOVAK | | | | 14. MOTHER'S MAIDEN NAME FRANCES KLEIS | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. FRANK J. NOVAK | | | |
| | | | | | | ADDRESS 817 S. MILTON AVE | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 162.1 I | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Lung | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | | | (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-3 19 71 to 3-9 19 71 that (I) (we) last saw the deceased alive on 3-9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Boo Kewn Kim | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 3-9-71 | |
| 23C. PHYSICIAN'S NAME (Type) Boo Kewn Kim | | | | 23D. ADDRESS Mercy Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/13/71 | | 24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR Raymond L. Kaczorowski | | 25C. FUNERAL DIRECTOR Raymond L. Kaczorowski | | ADDRESS 2525 FLEET ST. | | | |

L. 250

71 2477

BALTIMORE CITY HEALTH DEPARTMENT

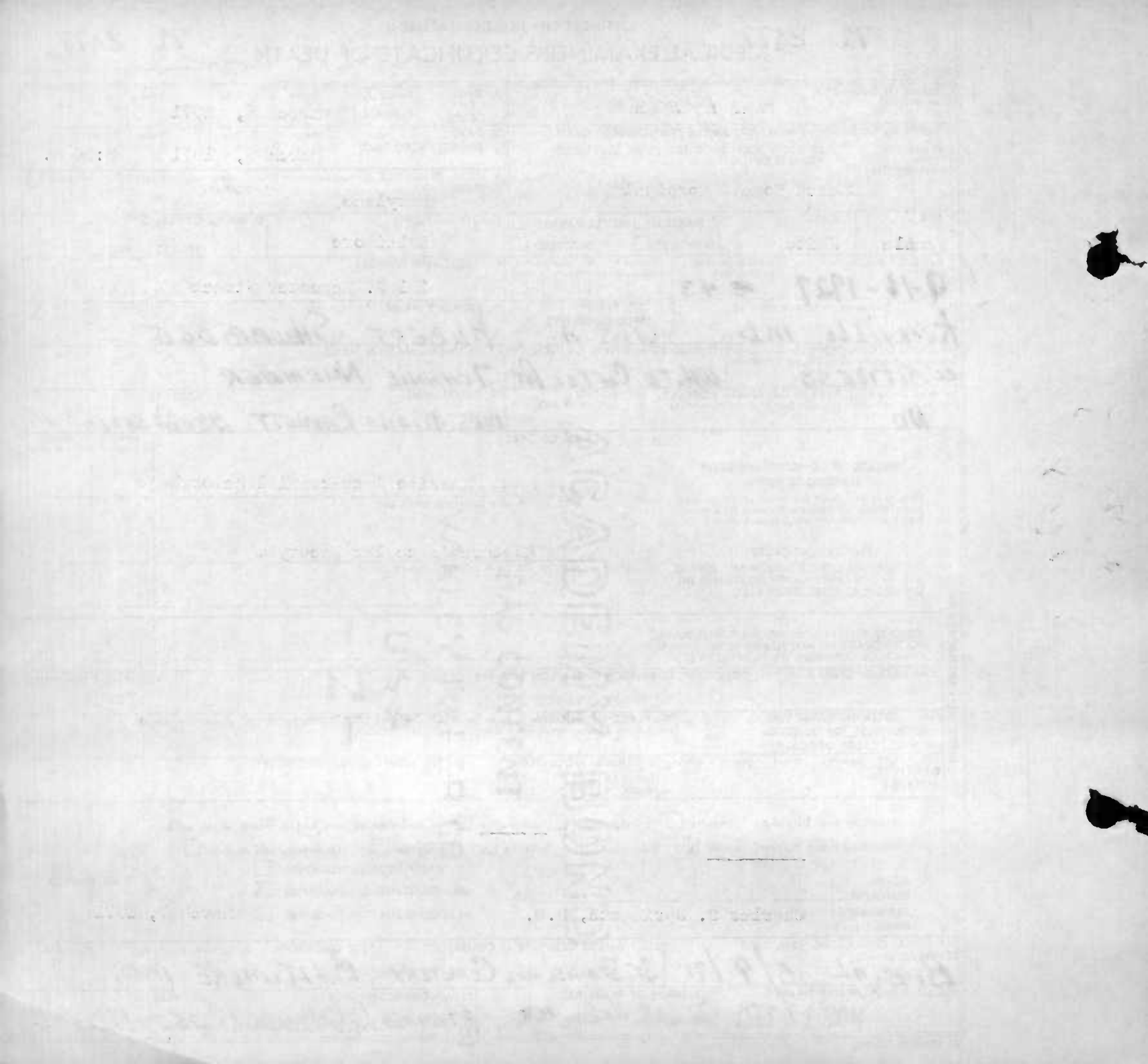
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2477

BIRTH NO.

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MARY L. LOGAN | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month March Day 6 Year 1971 Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital | | 3. DATE PRONOUNCED DEAD Month March Day 6 Year 1971 Hour 8:50 A. M. | |
| 6. SEX Female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 4-11-1927 | | 10. AGE (In years lost birthday) 43 | |
| 11. BIRTHPLACE (State or foreign country) KNOXVILLE MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS | | 14B. KIND OF BUSINESS OR INDUSTRY WHITE COFFEE POT | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. | |
| 13. FATHER'S NAME HUBERT STEUBRIDGE | | 15. MOTHER'S MAIDEN NAME JOHNNIE NUEMBER | |
| 18. INFORMANT MRS. DIANA BARNETT | | ADDRESS 230 PASADENA MD | |
| 19. 73071 | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Massive intracranial hemorrhage DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) Ruptured saccular aneurysm DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) | |
| 20A. DATE OF OPERATION 2/9/71 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 21. AUTOPSY? (Yes or No) Yes | |
| ACTUAL SIGNATURE Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/9/71 | |
| 24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR Robert J. [unclear] | |
| 25C. FUNERAL DIRECTOR Raymond L. Kaczorowski | | ADDRESS 2525 FLEET ST. | |



W 353

71 2478

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 2478

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

AUGUST L. WIEDENHOEFT

2. DATE
OF
DEATHKnown ☒

Month

Day

Year

Hour

Estimated ☐

March

7,

1971

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home & Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

March

7,

1971

12:35 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

602

6. SEX

Male

7. RACE

White

B.

MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

11-16-89

10. AGE (In years
lost birthday)

80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

236 N. Luzerne Avenue

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

AUGUST WIEDENHOEFT

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SHIPPING CLERK RET.

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or doles of service)17. SOCIAL
SECURITY NO.

215-01-8458A

18. INFORMANT

ADDRESS

MRS. CARRIE WIEDENHOEFT 236 N. LUZERNE AVE

19. 4124
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

March 7, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/10/71

24C. NAME OF CEMETERY or CREMATORY

Mt. Carmel Cms.

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 12 1971

25B. NAME OF REGISTRAR

Rafael E. Taylor, M.D.

25C. FUNERAL DIRECTOR

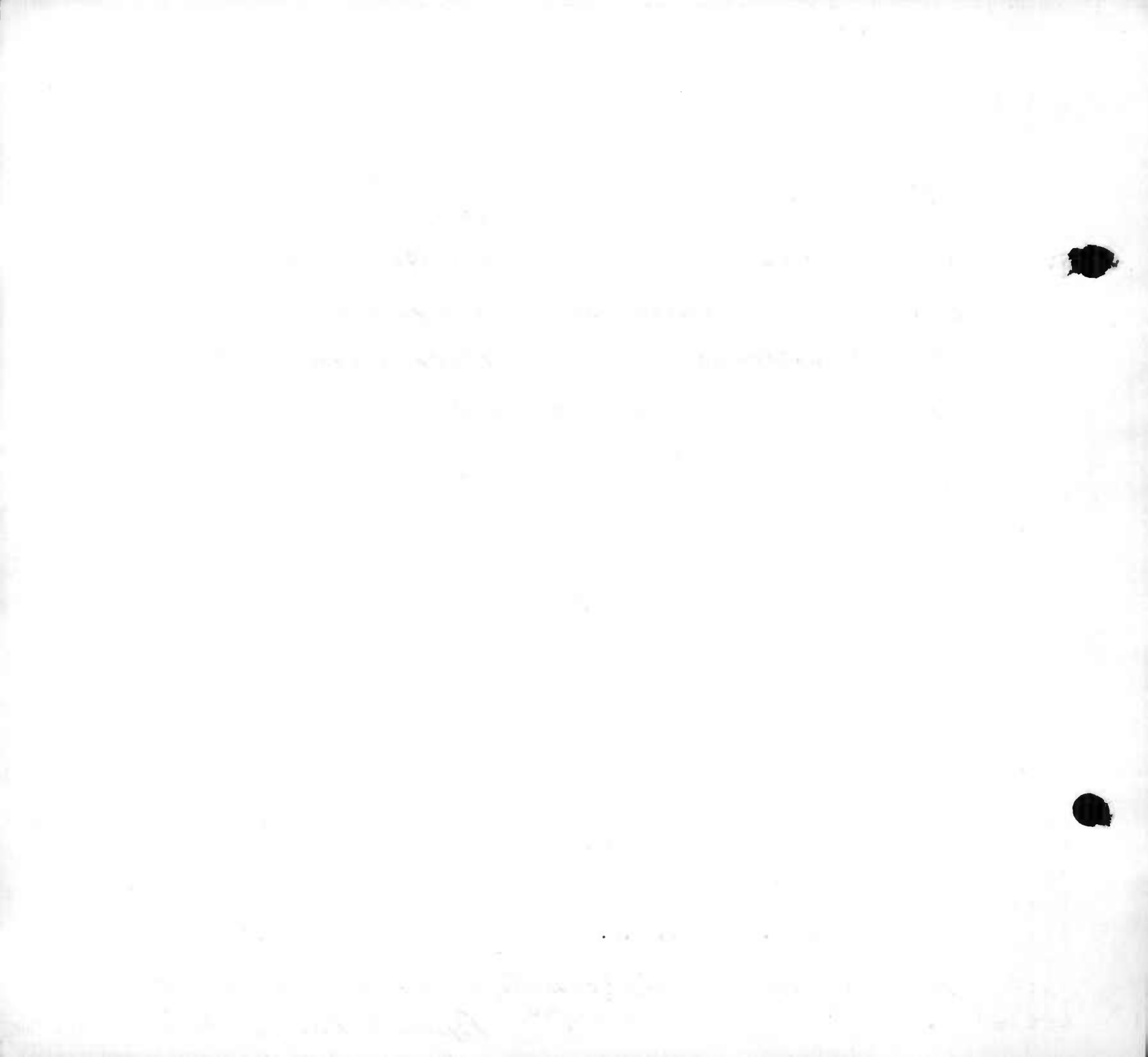
Raymond L. Kozynowski 2525 Fleet St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

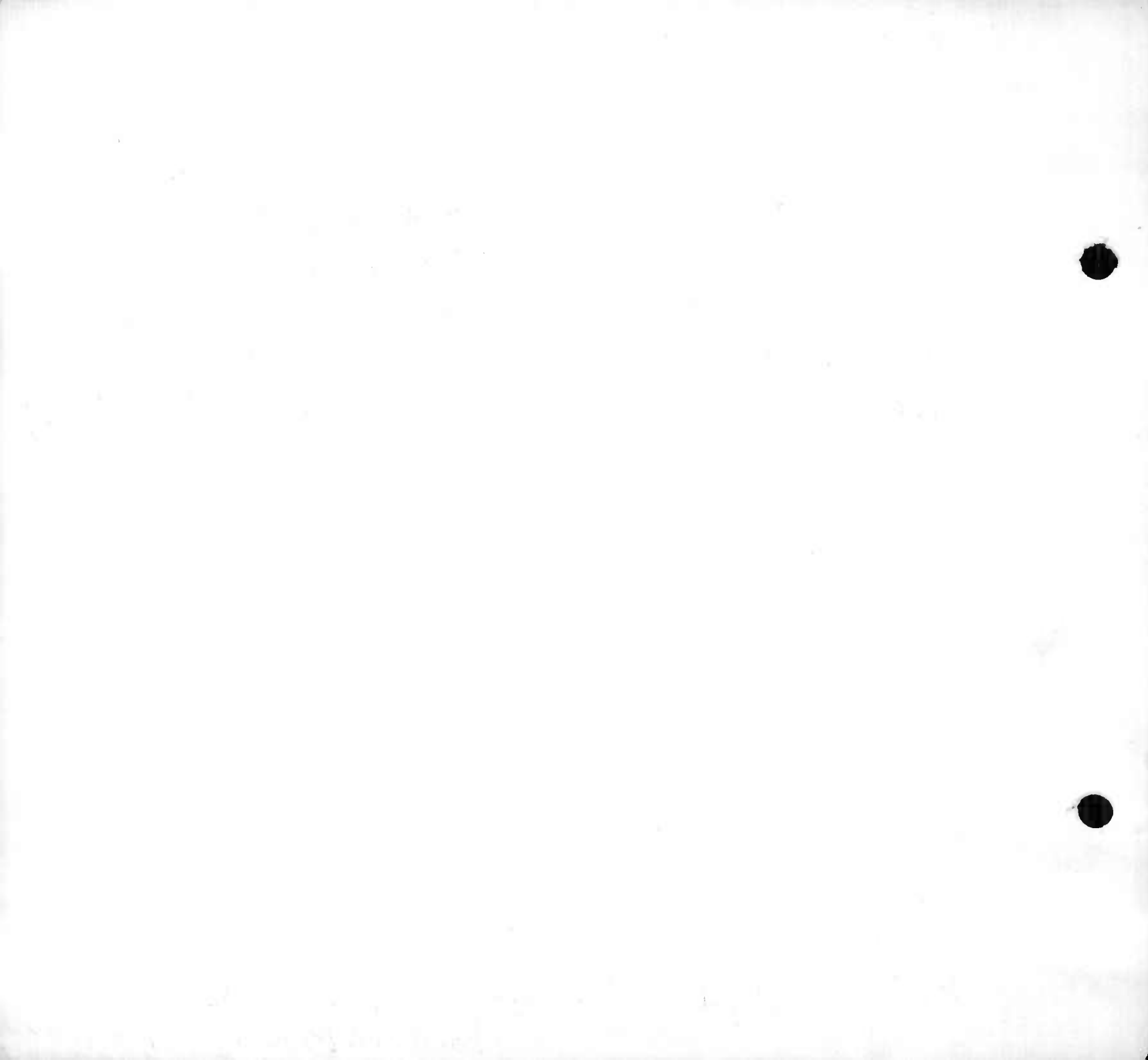
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CITY HEALTH DEPARTMENT | |
|---|---|---|--|--|---|
| BIRTH NO. 71 2479 | | | | REG. NO. 71 2479 | |
| 1. NAME OF DECEASED (Type or Print) BENJAMIN J. GRUNTkowski | | | 2. DATE AND HOUR OF DEATH MARCH 9 1971 9:10 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 GOULDS CONVALESCENT HOME | | | A. STATE MARYLAND B. COUNTY 2610 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 144 S. EAST AVE | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 9-8-1900 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN | | 10B. KIND OF BUSINESS OR INDUSTRY NELSON CORP. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JOHN GRUNTkowski | | 14. MOTHER'S MAIDEN NAME MARY STEPNIewski | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 216-01-4633 | | 17. INFORMANT ADDRESS MR. JOHN GRUNTkowski 435 S. ROBINSON ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 486 X 1 X 185 X | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pneumonia | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: Gumma of the Prostate; Chronic Heart Failure; Chronic Duodenal Ulcer; Diabetes | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/8/1971 to 3/9/1971 that (I) (we) last saw the deceased alive on 3/9/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert B. Bradley | | | 23B. DATE SIGNED 3/12/71 | | 23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE 3/13/71 | | 24C. NAME OF CEMETERY OR CREMATORY Holy ROSARY CEMETERY |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | | 25B. NAME OF REGISTRAR J. J. G. G. G. | | 25C. FUNERAL DIRECTOR ADDRESS RODOLPH L. KACZOROWSKI 2525 FLEET ST. |



| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. 71 2480 | |
|---|--|----------------------------------|--|--|--|------------------|--|
| 1. NAME OF DECEASED (Type or Print) ARMETA ALSTON | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 940 W. Saratoga St. | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 3 9 1971 6 p M. | | | |
| 6. SEX female | | | | 7. RACE negro | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1801 | | | |
| 9. DATE OF BIRTH 4/11/1899 | | | | 10. AGE (In years lost birthday) 71 | | | |
| 11. BIRTH PLACE (State or foreign country) Baltimore MD | | | | 12. CITIZEN OF USA | | | |
| 13. FATHER'S NAME Wm. H. Simms | | | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | |
| 15. MOTHER'S MAIDEN NAME Theresa Burne | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 17. SOCIAL SECURITY NO. 219-03-1997A | | | | 18. INFORMANT Jordan Russell Ryan Saratoga St | | | |
| 19. CAUSE OF DEATH 174X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of breast with metastases ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION 0 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 21. AUTOPSY? (Yes or No) no | | | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m. | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22F. HOW DID INJURY OCCUR? | | | | 23. | | | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/10/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Buried | | | | 24B. DATE 3/10/71 | | | |
| 24C. NAME of CEMETERY or CREMATORY Mt. Auburn | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT MAR 12 1971 | | | | 25B. NAME OF REGISTRAR Charles E. Kelly, Jr. | | | |
| 25C. FUNERAL DIRECTOR Wm. H. Ryan | | | | ADDRESS 6380 Gilman St | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|---|--------------------------------------|---|--|
| 7-520 71 2481 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2481 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>Thomas Dosa Lee</i> | | 2. DATE AND HOUR OF DEATH <i>2 1/2 P.M. 3-19-71</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1501</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital - Baltimore MD. 21201</i> | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <i>1348 N. Carey St</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>N.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8/14/1926</i> | 9. AGE (in years last birthday) <i>44</i> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>WASH. D.C.</i> | |
| 13. FATHER'S NAME <i>ROBERT MOORE</i> | | 14. MOTHER'S MAIDEN NAME <i>LEOLA WALKER</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>M. Hon Thomas 1348 N. Carey</i> | |
| 18. <i>396.9 I</i> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Heart failure</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Aortic and Mitral Valve Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Pt. had aortic and mitral valve replaced.</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>3-10-71</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Heart failure</i> | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3-8-71</i> 19 to <i>3-10-71</i> 19 that (I) (we) last saw the deceased alive on <i>3-10-71</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>ROSTAN FARDIN MD</i> | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) <i>ROSTAN FARDIN M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>3/10/71</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Not known</i> | |
| 24D. LOCATION (City, town, or County) (State) | | 24E. FUNERAL DIRECTOR <i>Pauline P. Myers 6387 Gilman</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 12 1971</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD.</i> | | 25C. ADDRESS <i>University of Maryland Hospital - Baltimore MD. 21201</i> | |



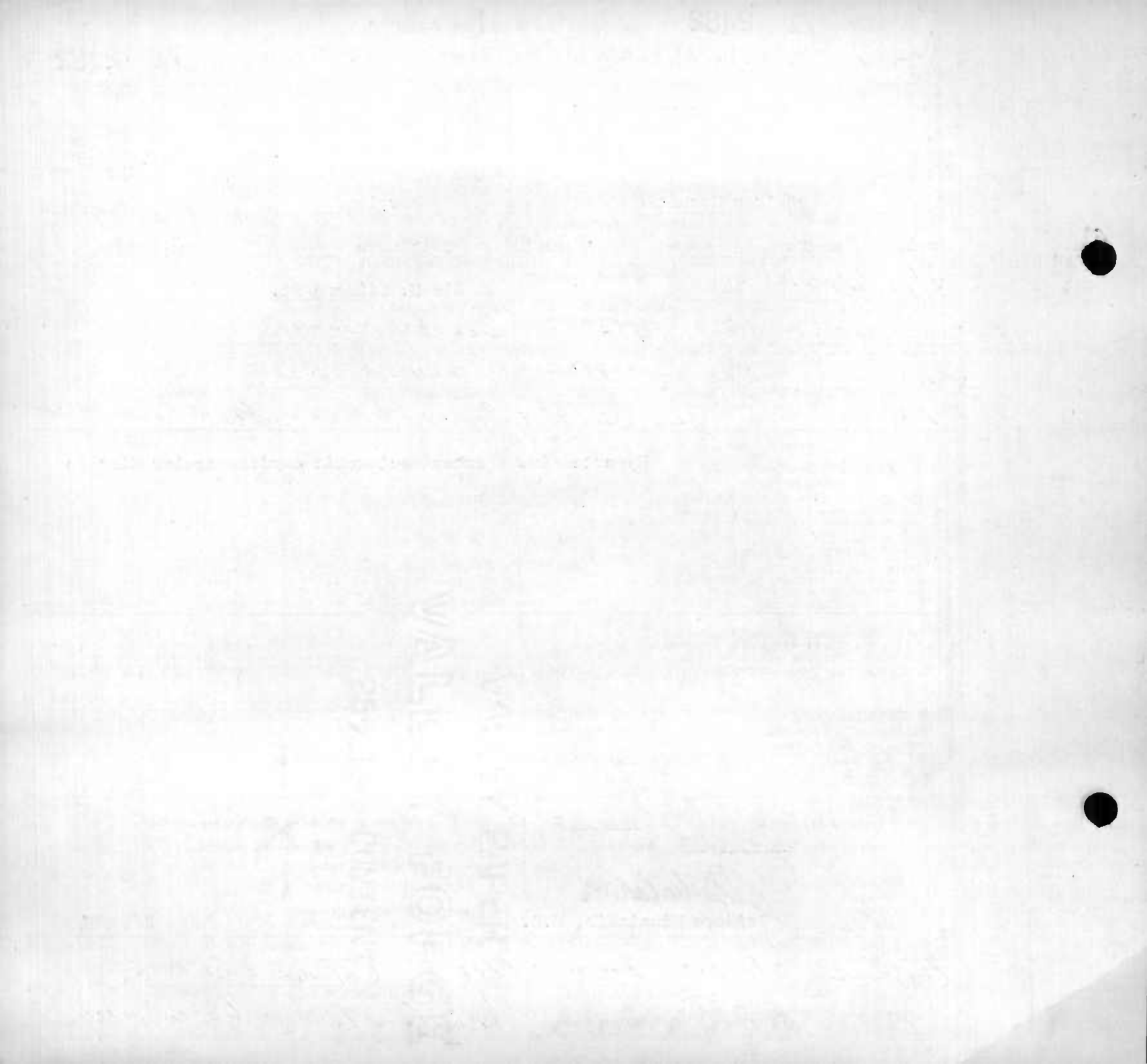
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2482

BIRTH NO

| | | | | | | | |
|---|----------------------------------|--|-------------------|--|---|---|------|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month | Day | Year | Hour |
| HUBERT NEALY | | | | | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 3. DATE PRONOUNCED DEAD | | Month | Day | Year | Hour |
| FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital | | 3 10 1971 1:30 a.m. | | | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | | B. COUNTY | | | |
| | | Maryland | | 1602 | | | |
| 6. SEX | 7. RACE | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | |
| male | negro | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 9. DATE OF BIRTH | 10. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | E. STREET AND NUMBER | | | |
| 3/12/1926 | 44 | | | 819 N. Gilmore St. | | | |
| 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | | | |
| Columbus Co N.C. | USA | | GOLDON NEALY | | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME | | | |
| Laborer | | Contractor | | VORLON ROBINSON | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS | | | |
| no | | 242-32-1184 | | CARLTON NEALY 819 N GILMORE ST | | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Hypertensive & arteriosclerotic cardiovascular disease | | | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | (B) | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | (C) | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | | |
| | | | | no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED | | 22F. HOW DID INJURY OCCUR? | | | |
| (APPROX.) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 23. | | | | | | | |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| Isidore Mihalakis, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | 3/10/71 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 3/12/71 | | Family Plot | | Columbus Co N.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| MAR 12 1971 | | Robert E. Taylor, M.D. | | Margaret R. Taylor | | 638 N Gilmore St | |

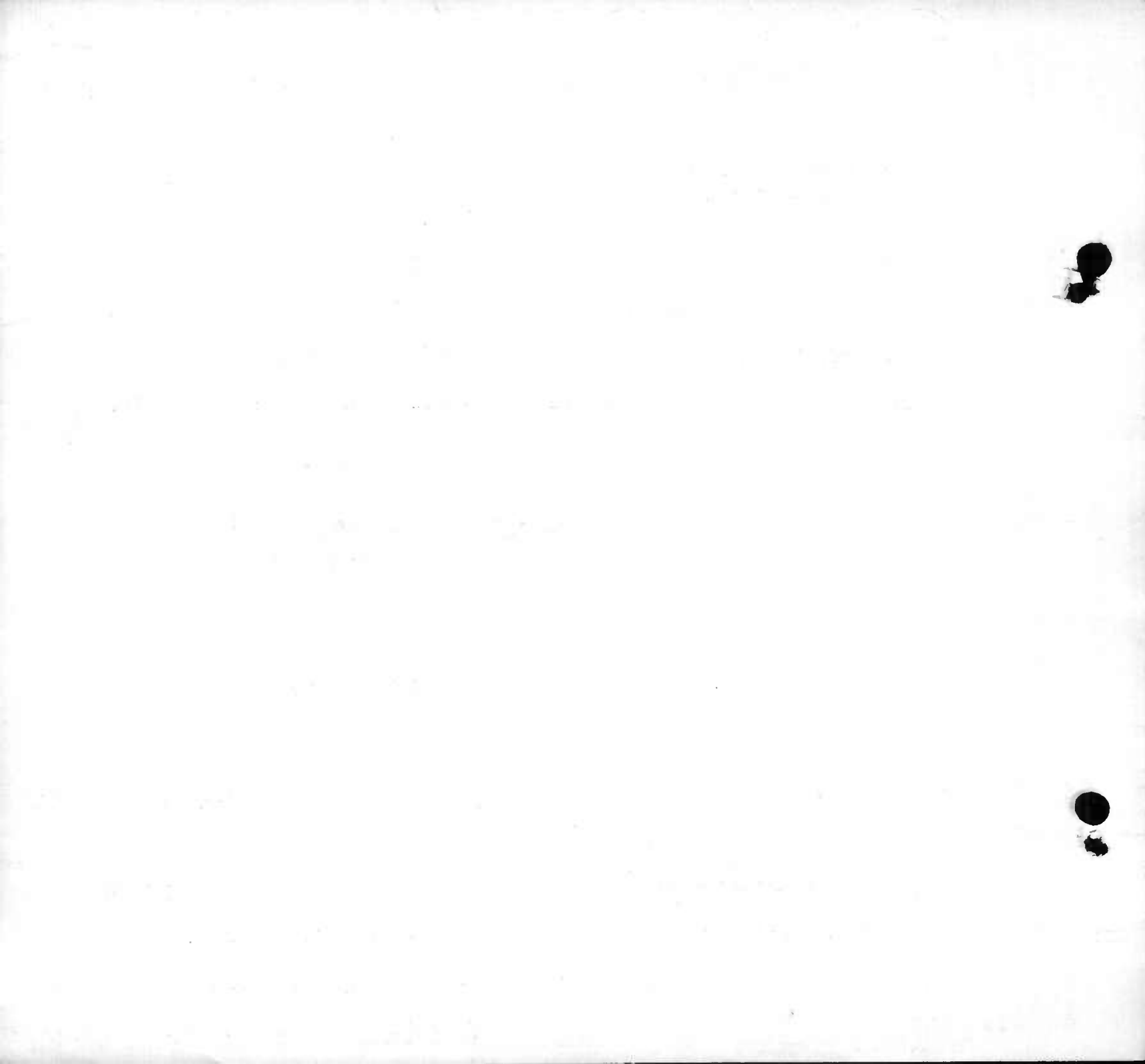


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2483</u> |
|--|--------------|---|-----------------------------|---|
| C-534 | | 71 2483 | | 71 2483 |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH |
| | | Jorge Irrizarry Candal (or) George | | Mar. 10, 1971 5:29 P M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 2X 3100 Wyman Parkway | | A. STATE Md. B. COUNTY | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER 533 N. Milton Ave. | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/23/12 | 9. AGE (in years last birthday) 58 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman | | 10B. KIND OF BUSINESS OR INDUSTRY Seafaring | | 11. BIRTHPLACE (State or foreign country) PR |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Joaquin Candal | | |
| 14. MOTHER'S MAIDEN NAME Felicitia Irrizarry | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 213-16-0429 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | | |
| 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Herniation of brain | | Days |
| | | (B) Carcinoma of right lung with diffuse metastases | | Months |
| | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from Mar. 3 19 71 to Mar. 10 19 71 that (I) (we) last saw the deceased alive on Mar. 10 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Gary E. Feldman, M.D. | | 23B. DATE SIGNED 3/11/71 | | 23C. PHYSICIAN'S NAME (Type) Gary E. Feldman, Surgeon (R) |
| 23D. ADDRESS US PHS Hospital, Balto, Md. | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | |
| 24B. DATE 3/19/71 | | 24C. NAME OF CEMETERY OR CREMATORY GARDEN OF FAITH | | 24D. LOCATION (City, town, or county) (State) TRUMPS MALL RD MD |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR GARY E. FELDMAN, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS DAPPEL BROS. 1800 E LOMBARD ST |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | REG. NO. | | | |
| C-155 | | 71 2484 | | Austin E. Chapman | | March 10, 1971 | | 10.30 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1229 Evesham Avenue | | | | A. STATE Maryland | | B. COUNTY 2748 | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> * NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 1229 Evesham Avenue | | | | | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-2-1903 | | 9. AGE (in years last birthday) 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Food Brokerage | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 13. FATHER'S NAME William E. Chapman | | | | 14. MOTHER'S MAIDEN NAME Lucy Childress | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-09-2690 | | 17. INFORMANT Mrs. Anne B. Chapman | | ADDRESS Same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH Rupture - Aortic Aneurysm. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Vascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES. 8 YEARS. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/21 1964 to 3/10 1971 that (I) (we) last saw the deceased alive on 3/3 1971 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Albert J. Himelfarb | | | | 23B. DATE SIGNED 3/11/71 | | 23C. PHYSICIAN'S NAME (Type) Dr. Albert J. Himelfarb | | | |
| 23D. ADDRESS 222 W. Cold Spring Lane | | 23E. DEGREE | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-1971 | | 24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Gardens Memorial | | 24D. LOCATION (City, town, or county) Timonium, | | (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR J. W. Jenkins | | 25C. FUNERAL DIRECTOR J. W. Jenkins & Sons Co. | | ADDRESS 4905 York Road Balto., Md. 21212 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2485 | |
|---|--|---|--|---|---|
| G-432 71 2485 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Brice W. Goldsborough | | March 11, 1971 7:30 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 5203 Falls Road | | | A. STATE Maryland | | |
| | | | B. COUNTY 2713 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 5203 Falls Road | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) |
| M | W | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8-17-1902 | 68 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Agent | | Real Estate | | Cambridge, Maryland | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Phillips Lee Goldsborough | | | Ellen Showell | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes WWII | | 219-30-6709 | | Mrs. Eleanor Goldsborough Same | |
| 18. 492 X I CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Emphysema | | | | sev. years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Arteriosclerotic cardio vascular disease | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-28 19 64 to 3-11 19 71 that (I) (we) last saw the deceased alive on 3-4 19 71 and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alfred G. Ossman Jr. | | | | 23B. DATE SIGNED 3-12-71 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Alfred G. Ossman, Jr. | | | | 23D. ADDRESS 1101 St. Paul Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3-13-1971 | | Christ Church | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 12 1971 | | J. W. Jenkins & Sons Co. | | 4905 York Road Balto., Md. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2486 | |
|---|--|--|--|--|--|
| J-520 71 2486 | | BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) JONES MR. CHARLES R. | |
| 2. DATE AND HOUR OF DEATH 3-12-71 2 15 A.M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 2005 | | 5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8/7/09 9. AGE (In years last birthday) 61 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN | | 10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME CHARLES JONES | | | |
| 14. MOTHER'S MAIDEN NAME VIRGINIA CASE | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. 213-07-6072 | | 17. INFORMANT WIFE Anna B Jones 2104 Ashton St ADDRESS | | | |
| 18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastasis carcinoma upper part of central nodes | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: CA larynx | | 1 year | |
| (C) Hy pertension | | | | | |
| 19A. DATE OF OPERATION 7/7/70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-11-71 to 3-12-71 that (I) (we) last saw the deceased alive on 3-11-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE P. C. KAHLE M.D. | | 23B. DATE SIGNED 3-12-71 | | 23C. PHYSICIAN'S NAME (Type) P. C. KAHLE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-15-71 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park | |
| 24D. LOCATION BALTO CITY | | 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | | |

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) Keith Jackson Irving | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 9, 1971 9:15 A.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 1801 | | C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX Male | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH April 15, 1964 | | 10. AGE (In years lost birthday) 6 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. | |
| 15. MOTHER'S MAIDEN NAME Elizabeth Jackson | | 18. INFORMANT ADDRESS Elizabeth Irving 119 N. Schroeder St | |

| | | |
|---|--|--|
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION E814.7 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH Multiple Injuries | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | |

| | | |
|---|---|--|
| 20A. DATE OF OPERATION 2 | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 21. AUTOPSY? (Yes or No) yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1015 W. Lexington Street 1802 |
| 22D. TIME OF INJURY (APPROX.) 3-9-71 7:50 A.M. | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 22F. HOW DID INJURY OCCUR? Pedestrian struck by car |

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Ronald N. Kornblum* M.D.
 EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.**

CHIEF MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAMINER ☒
 ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
3/9/71

| | | | |
|---|---|---|---|
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/12/71 | 24C. NAME of CEMETERY or CREMATORY Wt Auburn Cem. | 24D. LOCATION (City, town or county) (State) Balto. Md. |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 12 1971 | 25B. NAME OF REGISTRAR Robert E. Taylor, R.D. | 25C. FUNERAL DIRECTOR William's Funeral Home | ADDRESS 3197 Schroeder St. |

1-10-1918

1-10-1918

1-10-1918



Received of the Treasurer of the
Board of Directors of the
City of New York

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|---|--|
| 71 2488 REG. NO. | | BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Mr. William Allen</i> | | 2. DATE AND HOUR OF DEATH <i>3-8-71 11:10 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Ind.</i> B. COUNTY <i>2744</i> | |
| 5. SEX <i>MALE</i> 6. RACE <i>CAUC.</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <i>04-01-1887</i> 9. AGE (in years last birthday) <i>83</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i> | | | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> 12. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i> | |
| 13. FATHER'S NAME <i>Burgess B. Allen</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Wilhemena Semf</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i>212-03-8248</i> 17. INFORMANT <i>Wm. H. Allen - 4607 LaSalle Ave.</i> ADDRESS | |
| 18. <i>5901 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>SEPTICEMIC SHOCK</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>UTI - CHRONIC-RENAL INSUFFICIENCY, GI BLEEDING</i> (C) <i>Aspirin Aggravated</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indefinite medical examination) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>March - 6 1971</i> to <i>March 8 1971</i> that (I) (we) last saw the deceased alive on <i>March 8 1971</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Juan M. Calceira</i> DEGREE | | | | 23B. DATE SIGNED <i>3-8-71</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-11-1971</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1971</i> 25B. NAME OF REGISTRAR <i>Robert E. Fisher</i> 25C. FUNERAL DIRECTOR <i>John C. Miller Inc.</i> ADDRESS <i>6415 Belair Rd.</i> | | | |

V.S. 153

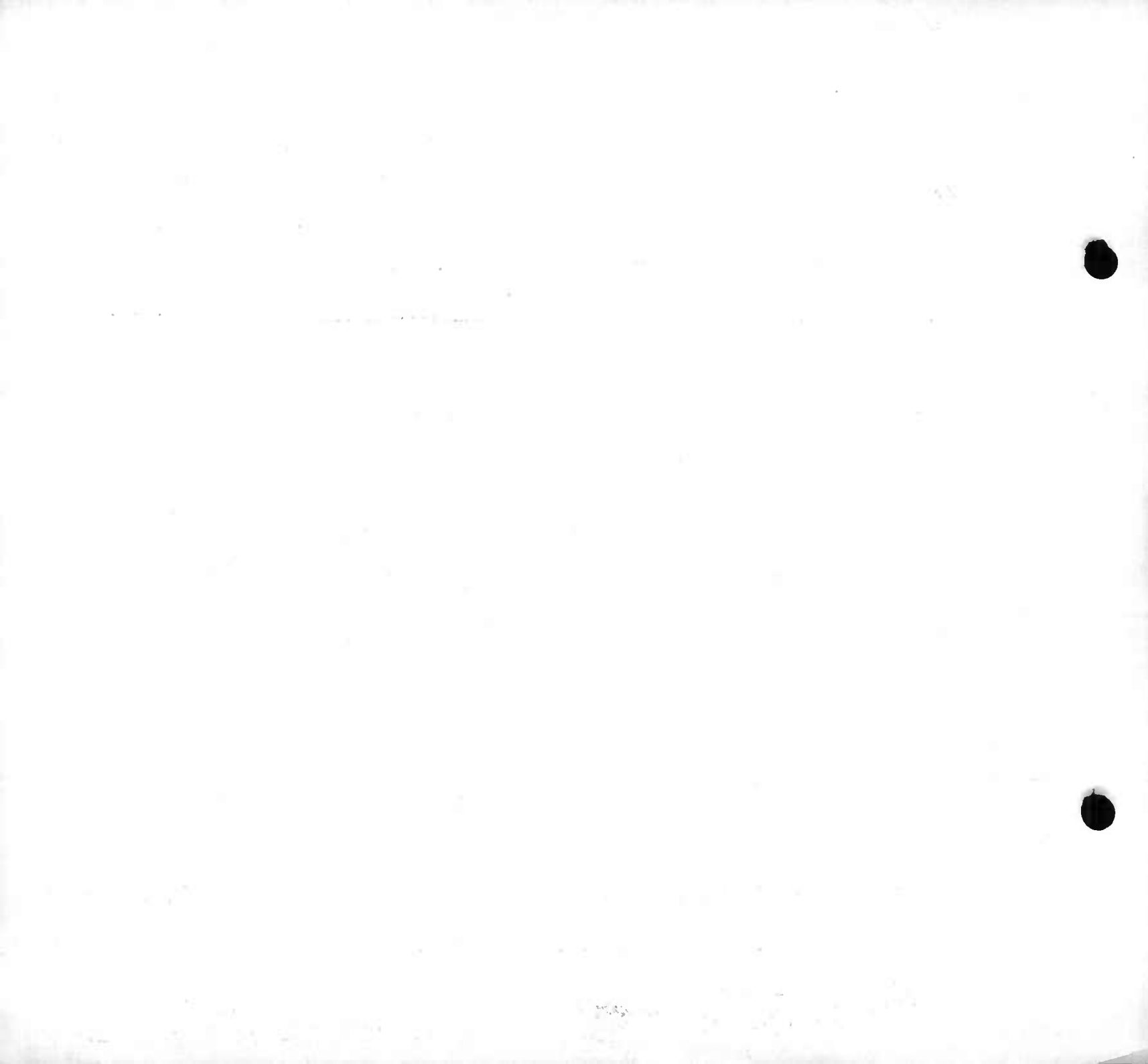
3-25-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

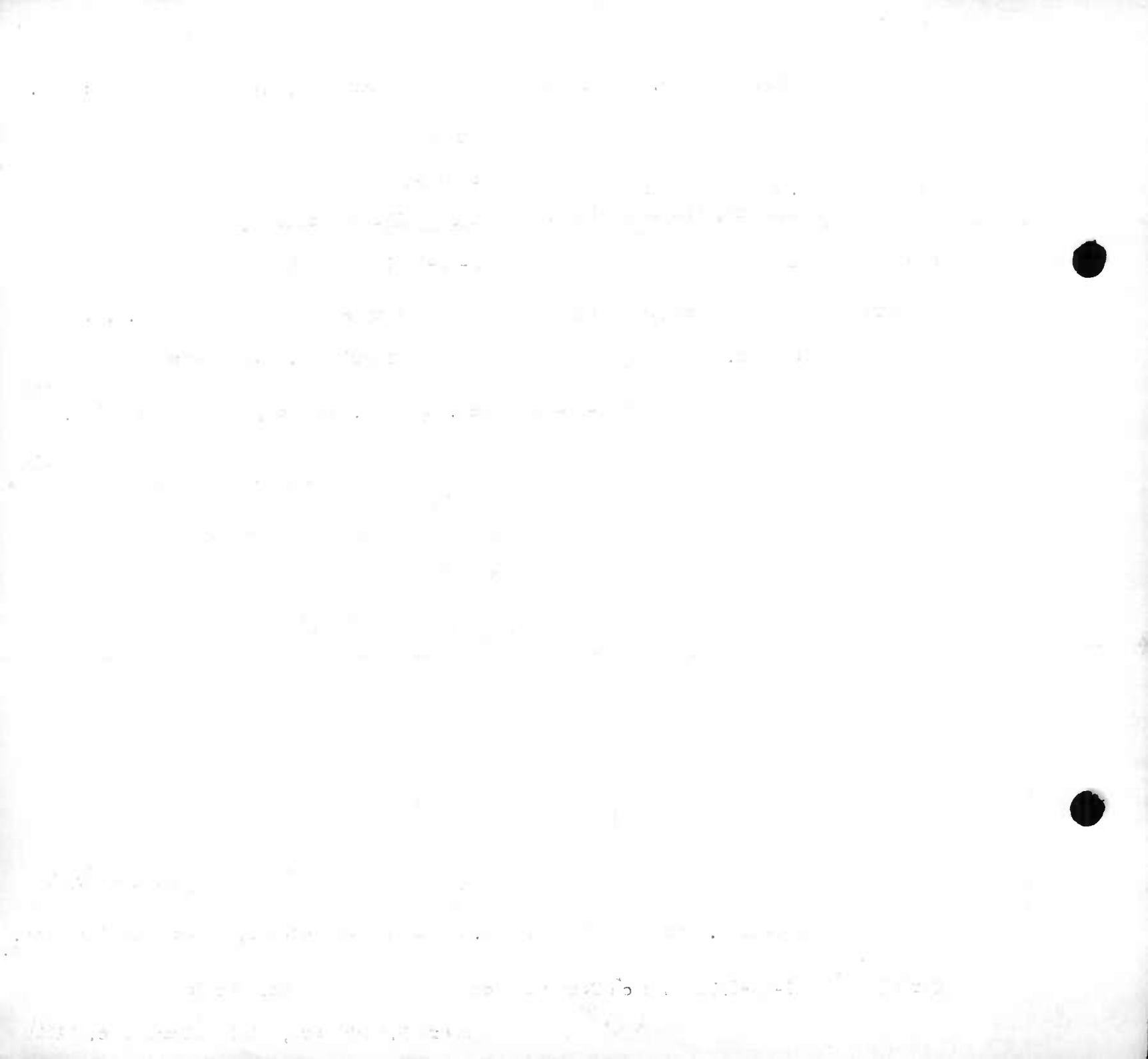
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2489</u> | |
|---|----------------------|--|--|--|--|
| H-430 71 2489 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. <u>71 2489</u> | | 1. NAME OF DECEASED (Type or Print) <u>Mrs. Esther Holliday</u> | | 2. DATE AND HOUR OF DEATH <u>3-8-71</u> <u>2:45</u> P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Keswick Home for Incurables</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>5615 Rimmel Ave. 21206</u> B. COUNTY <u>2734</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5615 Rimmel Ave. Baltimore, Maryland</u> | | | |
| 5. SEX <u>female</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 12, 1884</u> | 9. AGE (In years lost birthday) <u>86</u> | 10. UNDER 1 Yr. Months <u>11</u> Days <u>12</u> Hours <u>45</u> Min. <u>27</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pri/Duty Prac. Nurse</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u> | |
| 13. FATHER'S NAME <u>William Houghton</u> | | 14. MOTHER'S MAIDEN NAME <u>Esther Houghton</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>215-54-0416</u> | | 17. INFORMANT <u>Keswick Records</u> ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Cardiovascular Disease</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF <u>Probable Cerebral Thrombosis and Stroke</u> | | <u>1 yr.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Repeated Hemorrhagic Cystitis</u> | | | | <u>1 yr.</u> | |
| 19A. DATE OF OPERATION <u>3-11-71</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19 Oct</u> 19 <u>70</u> to <u>8 Mar</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>8 Mar</u> 19 <u>71</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Aubrey D. Richardson</u> | | 23B. DATE SIGNED <u>8 Mar 1971</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Aubrey D. Richardson, M.D.</u> | | 23D. ADDRESS <u>700 W. 40th Street</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-11-71</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Greentown Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>Greentown, Indiana</u> | | (State) <u>Indiana</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1971</u> | | 25B. NAME OF REGISTRAR <u>John A. Diller</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Inc-6415 Belair Road-21206</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

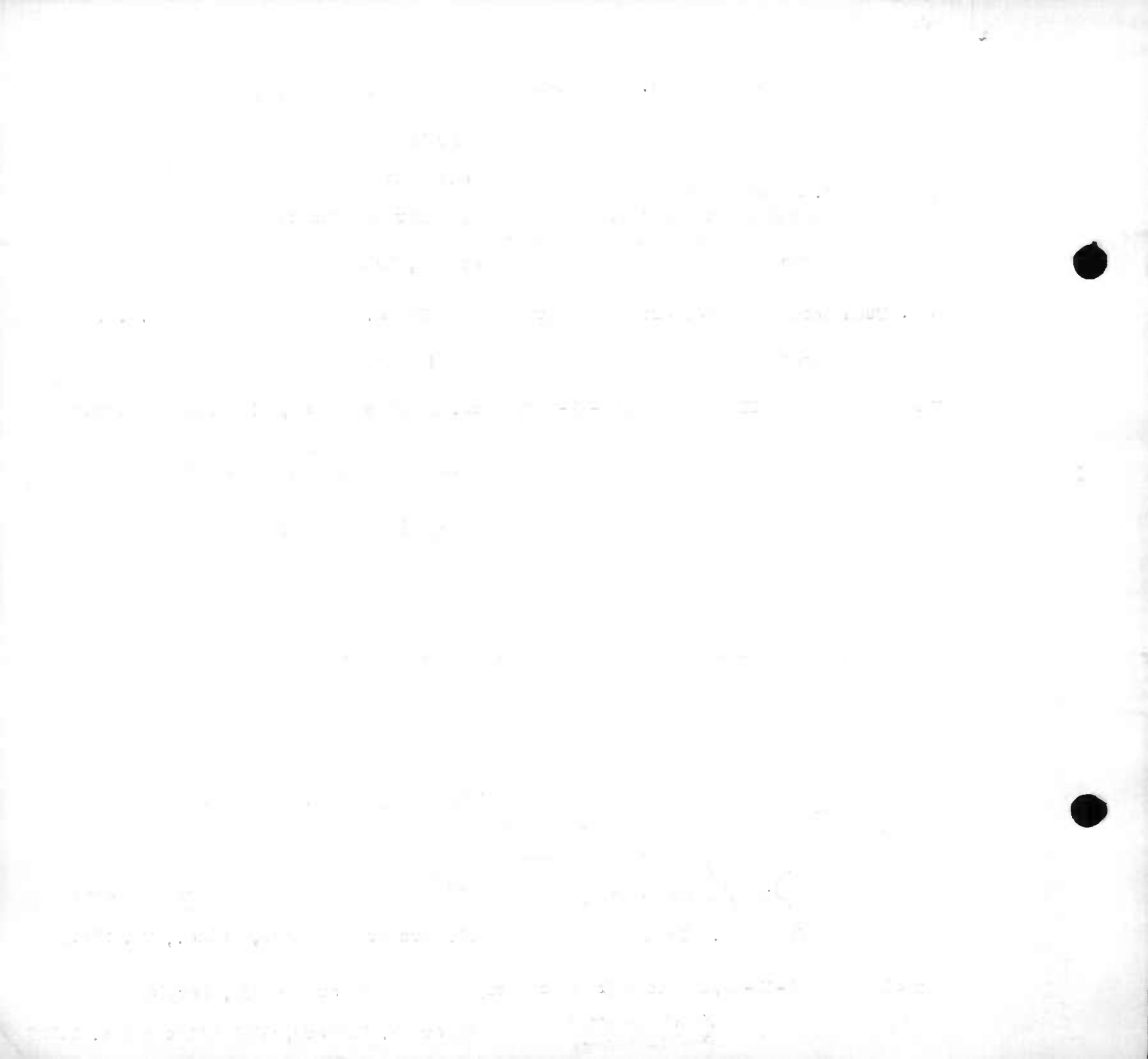
| | | | |
|--|---|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 71 2490 | |
| BIRTH NO. D-512 | | AGE 71 2490 | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM H. DEMPSEY | | 2. DATE AND HOUR OF DEATH March 9, 1971 12:16 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2005 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Emergency St. Agnes Hospital Room 40 Baltimore, Maryland 21229 | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male | | E. STREET AND NUMBER 2654 Wilkens Avenue | |
| 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-15-1907 | 9. AGE (In years last birthday) 63 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 10B. KIND OF BUSINESS OR INDUSTRY Westinghouse | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William T. Dempsey | | 14. MOTHER'S MAIDEN NAME Pearl M. Mullineaux | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-10-6163 | |
| 17. INFORMANT Mrs. Lydia E. Dempsey, 2654 Wilkens Ave. | | ADDRESS 21223 | |
| 18. 410.918-230.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Adiposcentic cardiomyopathy Infarction - congestive heart failure & cardiomegaly | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/12 19 71 to present 19 71 that (I) (we) last saw the deceased alive on 2/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Rafael H. Marin | | 23B. DATE SIGNED 3/9/71 | |
| 23C. PHYSICIAN'S NAME (Type) Rafael H. Marin M.D. | | 23D. ADDRESS St. Agnes Medical Center, Wilkens & Pine Hgts. Ave. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-12-1971 | |
| 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 15 1971 | | 25B. NAME OF REGISTRAR Charles J. ... | |
| 25C. FUNERAL DIRECTOR Howard H. Hubbard | | ADDRESS 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. <u>71 2491</u> | |
|--|--|---|--|---|--|
| BIRTH NO. <u>B-655</u> | | AGE <u>71</u> <u>2491</u> | | | |
| 1. NAME OF DECEASED (Type or Print) | | CHESTER J. BORMAN | | 2. DATE AND HOUR OF DEATH March 9, 1971 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2541</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u> St. Agnes Hospital Wilkins & Caton Avenues | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH March 6, 1910 | | 9. AGE (in years last birthday) 61 | | 10. UNDER 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. Technician | | 10B. KIND OF BUSINESS OR INDUSTRY Calvert Distillery | | 11. BIRTHPLACE (State or foreign country) Penna. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Unknown | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II | | | |
| 16. SOCIAL SECURITY NO. 176-12-7397 | | 17. INFORMANT Mrs. Pauline Borman, 4358 Parkton Street | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Thrombosis</u> (B) <u>A.P.C.V.D</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>2-3 yrs</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instantly</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb 6 1971</u> to <u>March 9 1971</u> that (I) (we) last saw the deceased alive on <u>March 5 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>John C. Pound</u> | | 23B. DATE SIGNED <u>3/10/71</u> | | 23C. PHYSICIAN'S NAME (Type) John C. Pound | |
| 23D. ADDRESS 3325 Frederick Avenue, Balto., Md. 21229 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-12-1971 | | 24C. NAME of CEMETERY or CREMATORY Crest Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Howard County, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 15 1971 | | 25B. NAME OF REGISTRAR <u>John C. Pound</u> | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkins Ave. 21229 | |



| BIRTH NO. | | 71 2492 | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2492 | |
|---|-------------------------|--|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) LOLA FODY | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2922 E. Pratt Street | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 7, 1971 10:12 A.M. | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 102 | | | | | | | |
| 6. SEX Female | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH 3-15-1915 | | 10. AGE (In years last birthday) 56 | | 11. BIRTHPLACE (State or foreign country) Florida | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME ----- | | 14. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14. B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME ----- | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT Mr. J.L. Fody | | ADDRESS 2922 E. Pratt St. | |
| 19. 174X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Adenocarcinoma of right breast DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20. A. DATE OF OPERATION | | | | 20. B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 22. A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22. B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22. C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | 22. D. HOW DID INJURY OCCUR? | | | |
| 22. E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Charles S. Springate, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DATE SIGNED March 7, 1971 | | | | | | | |
| 24. A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24. B. DATE 3-11-71 | | 24. C. NAME OF CEMETERY or CREMATORY Ger. Evang. Luth. Cem. | | 24. D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25. A. DATE REC'D BY HEALTH DEPT. MAR 15 1971 | | 25. B. NAME OF REGISTRAR Charles S. Springate, M.D. | | 25. C. FUNERAL DIRECTOR B. Dabrowski | | ADDRESS 2818 E. Baltimore St. | |

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| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. 71 2493 | |
|---|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) FANNIE M. YOUNTS | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year March 6, 1971 | | Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 19 N. Glover Street | | | | 3. DATE PRONOUNCED DEAD Month Day Year March 6, 1971 | | Hour P. 7:55 P. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 602 | | | | | | | |
| 6. SEX Female | | 7. RACE White | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 9. DATE OF BIRTH 4-18-1906 | | 10. AGE (In years lost birthday) 64 | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John Schilling | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing | | | | | |
| 15. MOTHER'S MAIDEN NAME Eleanor | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No. | | | | | |
| 17. SOCIAL SECURITY NO. 213-03-3809 | | 18. INFORMANT ADDRESS Mr. G. Younts 5718 Arnhem Rd. | | | | | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) (Partial) Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. UTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. | | (Partial) | | | | | |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | March 7, 1971 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-11-71 | | 24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 15 1971 | | 25B. NAME OF REGISTRAR Charles S. Springate | | 25C. FUNERAL DIRECTOR B. Dabrowski 2818 E. Baltimore St. | | ADDRESS | |

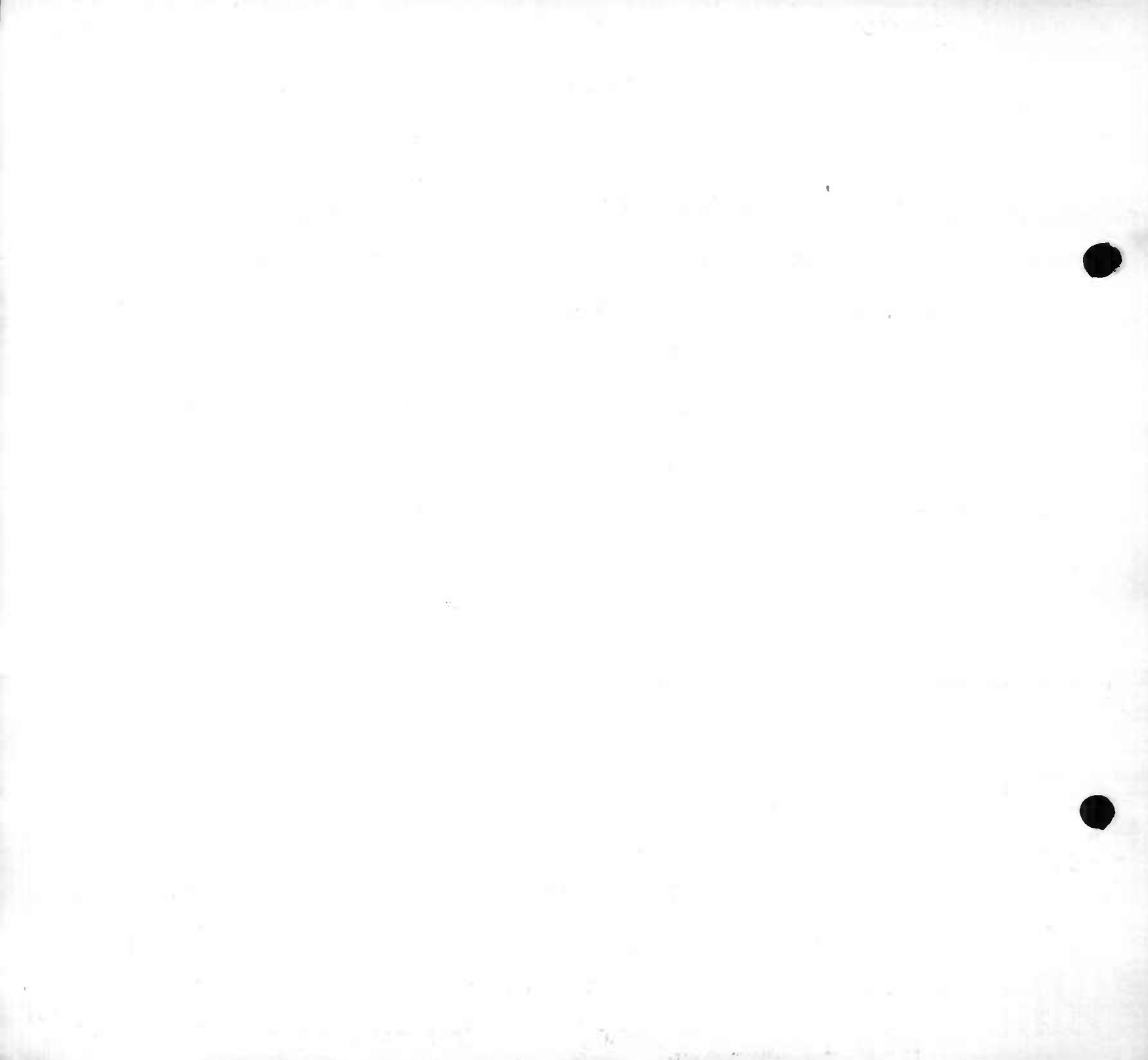
ACADEMIC BOND

WILEY & SONS

FUNERAL DIRECTOR: IMPORTANT

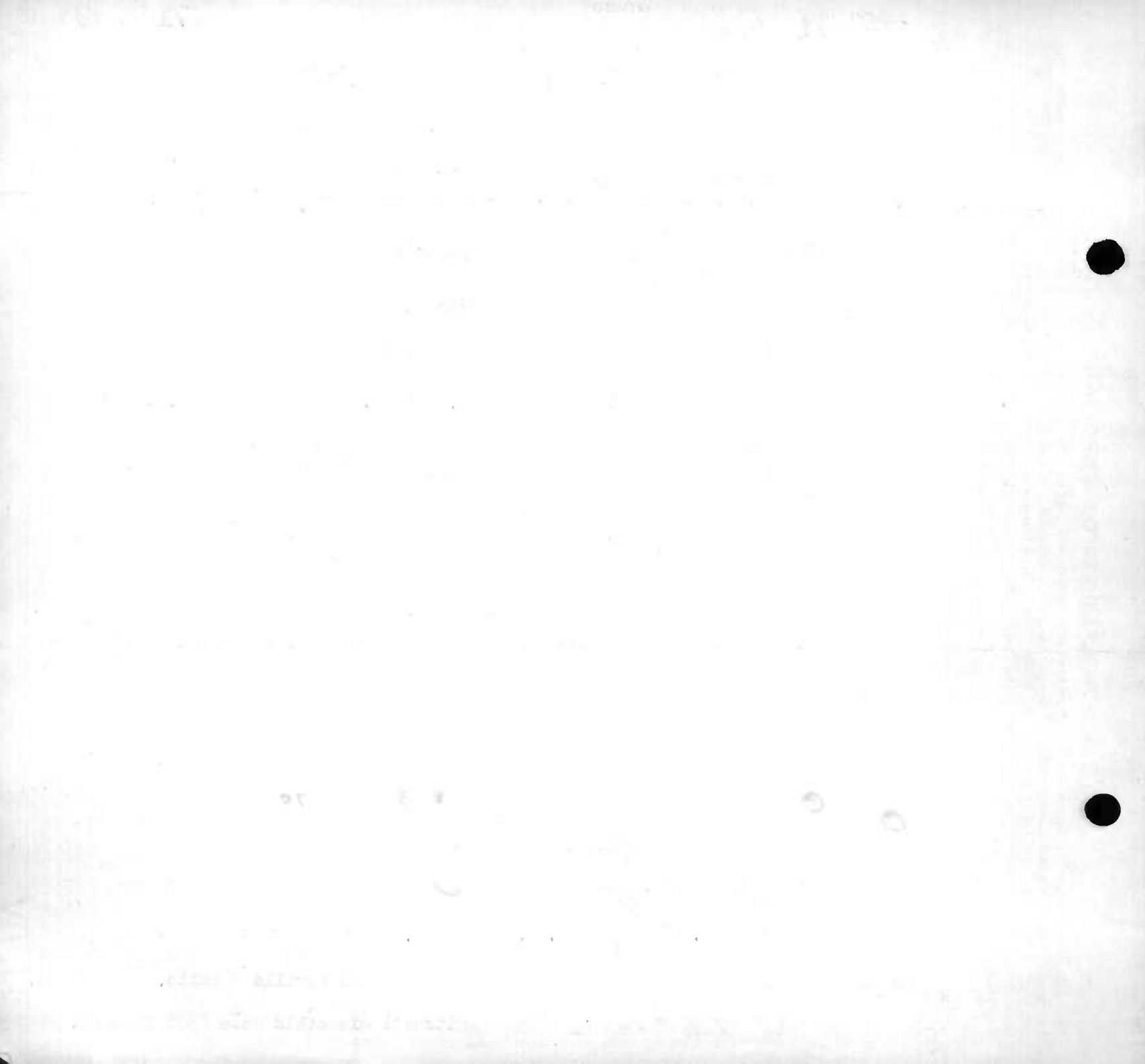
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2494</u> | |
|---|---------------------|---|--|---|---|
| S-400 71 2494 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Samuel R. Schley</u> | | | 2. DATE AND HOUR OF DEATH <u>3/5/71</u> <u>9:45 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1511</u> | | |
| | | | C. CITY OR TOWN <u>Baltimore</u> | | D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>3211 Dorchester Rd.</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-19-83</u> | 9. AGE (In years last birthday) <u>87</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRES. XXXX</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>PRODUCE</u> | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>GEORGE SCHLEY</u> | | | 14. MOTHER'S MAIDEN NAME <u>LYDIA</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-32-1729</u> | 17. INFORMANT <u>Estelle Schley</u> ADDRESS <u>3211 Dorchester Rd.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>441214-174X</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Rupture of abdominal aneurysm susp.</u> <u>arteriosclerosis</u> (B) <u>Renal cancer susp.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u> |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. (IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> 19 <u>71</u> to <u>3/5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3/5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>R. J. [Signature]</u> M.D. DEGREE | | | 23B. DATE SIGNED <u>3/5/71</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Abbott / Tsukamoto</u> M.D. DEGREE |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3/9/71</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>LORRAINE CEMETERY</u> | | 24D. LOCATION (City, town, or county) (State) <u>WOODLAWN MD.</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1971</u> | | 25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u> M.D. | | 25C. FUNERAL DIRECTOR <u>MITCHELL WIEDEFELD</u> ADDRESS <u>HOME 6500 Rd.</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-352 71 2495 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2495 | |
|--|--|---|--|---|--|---|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) HARRIET J STENQUIST | | | | 2. DATE AND HOUR OF DEATH 3/2/1971 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 LONG GREEN NURSING HOME 445 MELROSE AVE | | | | A. STATE Md. | | B. COUNTY Balto | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female | | | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 4/1/1877 | | | | 9. AGE (In years last birthday) 93 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Wisconsin | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Louis Fink | | | |
| 14. MOTHER'S MAIDEN NAME unknown | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 219 58 7157 | | | | 17. INFORMANT ADDRESS Mrs. Dave E. Kalinge Arcadia, California | | | |
| 18. CAUSE OF DEATH 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). AS CVD | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Wts Yrs Yrs | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 8-3 19 70 to 3-2 19 71 , that (2) (we) lost the deceased alive on 3-2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE R K Gundry | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-4-71 | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD K. GUNDRY M.D. | | | | 23D. ADDRESS 2 W. UNIVERSITY PKW | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/6/71 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Pikesville Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 15 1971 | | 25B. NAME OF REGISTRAR 2440 | | 25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home | | ADDRESS 6500 York Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>71 2496</u> | |
|---|--|---|--|---|--|
| Z-400 71 2496 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Zeul-1771- Conrad W.</u> | | 2. DATE AND HOUR OF DEATH <u>3-8-71 5:10 a. m.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Keswick</u> | | 3709 Fairview Ave BALTO. MD. 21216 | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Keswick</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>m</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Refractories Co.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>RET. SALESMAN</u> | | 8. DATE OF BIRTH <u>9-28-1885</u> | |
| 13. FATHER'S NAME <u>Gerhard P. Zeul</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Winklemann</u> | | 9. AGE (in years last birthday) <u>85 yrs</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>no</u> | | 16. SOCIAL SECURITY NO. <u>220-09-5525</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore-1771-</u> | |
| 17. INFORMANT <u>Keswick Records-</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Coronary Thrombosis</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 65</u> to <u>8 Mar 19 71</u> that (I) (we) lost saw the deceased alive on <u>8 Mar 19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Harold P. Biehl MD</u> | | | | 23B. DATE SIGNED <u>8 Mar 71</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>HAROLD P. BIEHL</u> | | | | 23D. ADDRESS <u>Wiley Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>3/10/71</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>LOUDON PARK</u> | |
| 24D. LOCATION <u>BALTIMORE MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1971</u> | | 25B. NAME OF REGISTRAR <u>NICHOLS-WIEDEFELD HOME</u> | |
| 25C. FUNERAL DIRECTOR <u>6500 YORK</u> | | 25D. ADDRESS | | 25E. ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 71 2497 | |
|--|-------------------------|---|---|---|---|
| C-410 71 2497 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Catherine S. Culp | | | 2. DATE AND HOUR OF DEATH 3/6/1971 8⁰⁰ PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 211 Hollen Rd. | | | A. STATE Md. B. COUNTY Balto | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 211 Hollen Rd. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/29/1923 | 9. AGE (In years last birthday) 47 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 13. FATHER'S NAME Thomas P. Smith | | 14. MOTHER'S MAIDEN NAME Estelle M. Berg | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219184987 | | 17. INFORMANT Robert W. Culp | |
| | | | | ADDRESS Same | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma | | | 2 years | | |
| (B) Carcinoma Breast DUE TO, OR AS A CONSEQUENCE OF: | | | 10 years | | |
| (C) _____ | | | _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None | | | _____ | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-6 19 71 to 3-6 19 71 , that (I) (we) last saw the deceased alive on 3-6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Eugene P. Riley MD | | | | 23B. DATE SIGNED 3-7-71 | |
| 23C. PHYSICIAN'S NAME (Type) Eugene P. Riley MD | | | | 23D. ADDRESS 7620 York Road | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/71 | | 24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem Gds | |
| | | | | 24D. LOCATION (City, town, or county) (State) Cockeysville Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 15 1971 | | 25B. NAME OF REGISTRAR Charles E. Kelly | | 25C. FUNERAL DIRECTOR Mitchell Wiedefeld | |
| | | | | ADDRESS Home 6500 York Rd. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. E-463 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 71 2498 | |
|---|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| JOSEPHINE ELARDO | | | | 3-10-71 @ 2 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL | | | | A. STATE Maryland B. COUNTY Baltimore | | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | C. CITY OR TOWN Baltimore, M.D. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| E. STREET AND NUMBER 1619 Riverwood Rd 21221 | | | | 5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 3-1-01 9. AGE (In years last birthday) 70 | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 10A. KIND OF BUSINESS OR INDUSTRY Home | | | | 12. CITIZEN OF WHAT COUNTRY? Italy | | 13. FATHER'S NAME Catoldo Scarpello | |
| 14. MOTHER'S MAIDEN NAME Mary Sodora | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - | | | |
| 16. SOCIAL SECURITY NO. 218 09 85440 | | | | 17. INFORMANT Geo. P. Elardo Same | | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO/RESPIR INSUFFIC | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (B) METASTASIS | | | |
| ANTECEDENT CAUSES | | | | DUE TO, OR AS A CONSEQUENCE OF: (C) CARCINOMA OF OVARY | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 71 to 3-10-19 71 that (I) (we) last saw the deceased alive on 3-9-19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 3-10-71 | | 23C. PHYSICIAN'S NAME (Type) [Signature] | |
| 23D. ADDRESS The Johns Hopkins Hospital | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 3/12/71 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | | 24D. LOCATION (City, town, or county) Baltimore Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 15 1971 | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR [Signature] | | ADDRESS 1407 Eastern Ave. | |

222

712

[illegible]

G-456

71 2499

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 2499

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) FRANK GILNER | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour March 4, 1971 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2624 Fait Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year Hour March 4, 1971 8:10 A. M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH DEC. 7, 1903 | | 10. AGE (in years lost birthday) 67 | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. 213-12-6974 | |
| 13. FATHER'S NAME JOSEPH GILNER | | 15. MOTHER'S MAIDEN NAME SOPHIA BANASZAK | |
| 18. INFORMANT MSR. SOPHIA TOLL | | ADDRESS 3506 Rosckampfe #14 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/6/71 | |
| 24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 15 1971 | | 25B. NAME OF REGISTRAR Robert E. Farber, R.D. | |
| 25C. FUNERAL DIRECTOR | | ADDRESS Raymond L. Kaczmarewski 2525 Keok St. | |

ACAPITIMX 10000

NO. 10000

NO. 10000

Charles F. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Y-621 2500 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 71 2500 | |
|---|---------------------|---|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) SAMUEL YAROSHEVICH | | | | 2. DATE AND HOUR OF DEATH 3/12/71 4:45 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE MD B. COUNTY 201 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL 35 BALTIMORE, MD 21231 | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 2019 E. PRATT ST. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/22/07 | 9. AGE (In years last birthday) 64 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) METAL WORKER | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 13. FATHER'S NAME ALEX YAROSHEVICH | | | | 14. MOTHER'S MAIDEN NAME OLGA HOMIC | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213073007 | | 17. INFORMANT PATIENT | |
| 18. 70331 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) SEPSIS (PERITONITIS) | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 DAYS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RESECTION OF SIGMOID CA | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: CA OF SIGMOID | | 21 DAYS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2/21/71 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF SIGMOID | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N.A. | | 21C. WHERE DID INJURY OCCUR? N.A. | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) N.A. | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? NA | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/12/71 19 to 3/12 19 71 that (I) (we) last saw the deceased alive on 3/12/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ricardo M. T. Watson M.D. | | | | 23B. DATE SIGNED 3/12/71 | | 23C. PHYSICIAN'S NAME (Type) RICARDO M. T. WATSON, M.D. | |
| 23D. ADDRESS 100 N. BROADWAY, BALTO MD. | | | | 23E. FUNDING DIRECTOR THE DIRPEL BROS INC 1800 E LONGFORD ST | | 23F. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE MAR 13-71 | | 24C. NAME OF CEMETERY OR CREMATORY MT CARMEL CEM | | 24D. LOCATION (City, town, or county) (State) ODONNELL ST BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 15 1971 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. | | 25C. FUNDING DIRECTOR THE DIRPEL BROS INC 1800 E LONGFORD ST | | 25D. ADDRESS | |

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